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TREATING MEDICAL MALPRACTICE CLAIMS  
UNDER A VARIANT OF THE BUSINESS  
JUDGMENT RULE

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*Andrew S. Boutros†*

In 524 A.D., the Roman writer Boethius introduced the world to the concept of the "wheel of fortune" through his widely read and highly influential book, *The Consolation of Philosophy*.<sup>1</sup> Written immediately prior to his execution, his work examines the meaning of life and seeks to identify the supreme source of happiness from among a catalog of desires, namely: power, fame, riches, honor, pleasure, and God. Before his exile from Rome, Boethius had been a distinguished statesman and scholar, and a man recognized for his great probity, power, and wealth. After being accused of treason, however, Boethius suffered a sudden reversal of fortune that led to public disrepute, banishment, and eventually execution.

In his book, Boethius is aided in his quest to discover true happiness by Lady Philosophy, the embodiment of the ultimate achievements of human reason. During one of his dialogues with Lady Philosophy, Boethius is consoled in his current misfortune with gentle rhetoric and soothing melodies of music. Lady Philosophy first reminds Boethius of the capricious ways of the Goddess Fortune, who she describes as a "two-faced . . . blind goddess."<sup>2</sup> Lady Philosophy explains that,

[i]f you hoist your sails in the wind, you will go where the wind blows you, not where you choose to go; if you put seeds in the ground, you must be prepared for lean as well as abundant years.

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1 ANICIUS MANLIUS SEVERINUS BOETHIUS, *THE CONSOLATION OF PHILOSOPHY* 21 (Richard Green trans., Bobbs-Merrill Co. 1962) (524 A.D.).

2 *Id.* at 22.

You have put yourself in Fortune's power; now you must be content with the ways of your mistress.<sup>3</sup>

Lady Philosophy continues,

When Fortune turns her wheel with her proud right hand, she is as unpredictable as the flooding of the Euripus;<sup>4</sup> at one moment she fiercely tears down mighty kings, at the next the hypocrite exalts the humbled captive. She neither hears nor cares about the tears of those in misery; with a hard heart she laughs at the pain she causes. This is the way she amuses herself; this is the way she shows her power. She shows her servants the marvel of a man despairing and happy within a single hour.<sup>5</sup>

Lady Philosophy then vicariously stands in the shoes of the Goddess Fortune and puts forth Fortune's argument justifying the fickle nature of her ways. She asserts,

Why should I [Fortune] alone be deprived of my rights? The heavens are permitted to grant bright days, then blot them out with dark nights; the year may decorate the face of the earth with flowers and fruits, then make it barren again with clouds and frost; the sea is allowed to invite the sailor with fair weather, then terrify him with storms. Shall I, then, permit man's insatiable cupidity to tie me down to a sameness alien to my habits? Here is the source of my power, the game I always play: I spin my wheel and find pleasure in raising the low to a high place and lowering those who were on top. Go up, if you like, but only on condition that you will not feel abused when my sport requires your fall. Didn't you know about my habits?<sup>6</sup>

It would seem that in the context of the tort system the answer for many plaintiffs and defendants is no. Persons who have been forced to put their medical claims and defenses in the hands of judges and juries are often seen as relying on a system whose adjudication of medical disputes resembles the whimsical ways of the Goddess Fortune.<sup>7</sup> Just as Fortune at times exalts a person—without cause—so too the tort system allows for undeserving plaintiffs to receive amounts far in

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3 *Id.*

4 Euripus is a narrow strait that separates the island of Euboea from the coast of Boeotia. It is well known for its irregular tides. *Id.* at 23 n.1.

5 *Id.* at 23.

6 *Id.* at 24.

7 For discussions, pro and con, on jury reliability in medical malpractice cases, see Jeffrey O'Connell & Christopher Pohl, *How Reliable Is Medical Malpractice Law? A Review of "Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets and Outrageous Damage Awards"* by Neil Vidmar, 12 J.L. & HEALTH 359, 367-69 (1997-1998).

excess of their actual losses or even recover in spite of unmeritorious claims. The antithesis holds true as well. Just as Fortune erratically humbles the mighty to desperation and sorrow, so too the tort system inexplicably sentences worthy victims to recover less than their fair share of compensation or nothing at all. Therefore, like the Goddess Fortune, the tort system appears to demand that those who place their claims in its hands expect that matters will seemingly be resolved by lot, not merit. Under the tort system, uncertainty and chance too often are the rule—not the exception. This viewpoint is shared by two eminent Harvard scholars—one a physician, the other a lawyer:

Concern for the functioning of the malpractice litigation system led the State of New York more than 10 years ago to ask us, along with a group of other Harvard physicians, lawyers, economists, and statisticians, to evaluate that system.

Our Harvard medical practice study found both the medical and legal systems in urgent need of change. We discovered that in New York hospitals, more than 100,000 patients were injured annually because of medical management practices, more than one-quarter from negligence. (More recently we have found a similar picture in Utah and Colorado.) Fewer than 7 percent of New York's injured patients received compensation through the courts, however, and of those fewer than 20 percent were injured because of negligence. So the legal system is even more prone to error than the medical system it attempts to judge.

In addition, the system is wasteful in economic terms: We found that the nearly \$1 billion paid in New York for malpractice insurance during the year we studied would have been enough to compensate all New York patients injured, whether negligently or not, for medical costs, lost wages, and home care costs.

And, most important, we found little or no evidence that the current malpractice regime improves the quality of subsequent medical care. Surely that must be the larger societal goal of any system of medical accountability.<sup>8</sup>

## INTRODUCTION

Arbitrary awards have undermined the two goals of the current tort system as applied to medical malpractice, namely compensation and deterrence.<sup>9</sup> The prime point of adjudicating medical malprac-

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8 Howard Hiatt & Paul Weiler, *No-Fault Medical Coverage Would Cure Many Ills*, BOSTON GLOBE, Nov. 5, 1999, at A27 (referring to HARVARD MED. PRAC. STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990)).

9 See generally PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991).

tice claims is to fairly compensate injured persons for the negligence of physicians and to deter the substandard delivery of medical care. As over 150 years of adjudicating medical malpractice as torts have demonstrated, the tort system is incapable of achieving either of these goals.

As the senior author of this Article has insisted for many decades, the principal fault of the current tort system is that fault itself is its bedrock. That is, the tort system operates on the premise that there can be no recovery by a claimant unless the alleged tortfeasor has been at fault.<sup>10</sup> In the case of medical injuries, fault consists of negligence. The problem is that many medical injuries cannot be attributed to any individual's fault, and even if there is fault, it is very often difficult to prove. This is especially true when one considers the laundry list of potentially negligent defendants that includes, but is not limited to, physicians, hospitals, equipment manufacturers, and drug manufacturers—all or none of whom could have been responsible for a claimant's injuries.<sup>11</sup> A recent study by the prestigious Institute of Medicine emphasizes that adverse results from health care commonly stem from complex, multicausal, systemic interactions, not from any monocausal individual mistake. This raises a real cultural clash with typical medical malpractice litigation in which according to an extensive study published by the American Psychological Association, plaintiffs' lawyers seek, and then concentrate on, "melodramatic" proof of an individual actor's error on which to focus jury attention.<sup>12</sup>

In the medical context, any fault, whether multi or mono-causal is also often extremely difficult to prove due to the complexity of the litigation arising from the incredibly intricate nature of the human body. The human body is composed of almost infinitely elaborate interlocking parts that baffle nearly all who study them. Consequently, it is only natural that triers of fact find it extremely difficult to separate adverse consequences due to a physician's negligence—if any—from preexisting conditions that may have further developed during the course of treatment. Such difficulty is only exacerbated in the course of a trial since time only permits triers of fact a crash course in

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10 *E.g.*, JEFFREY O'CONNELL, *THE BLAME GAME* (1987); *see also* G. EDWARD WHITE, *TORT LAW IN AMERICA* 164 (1980).

11 *See* Henson Moore & Jeffrey O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267, 1268 (1984). *See generally* COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 1999) [hereinafter IOM] (suggesting that medical errors are typically the result of a confluence of factors, and proposing a system of error reduction).

12 NEIL FEIGENSON, *LEGAL BLAME* 151-69 (2000).

medicine that usually spans only hours or days, yet covers complex material that takes several years of study by medical students. Moreover, the fact that triers are often presented with conflicting and, perhaps, equally persuasive expert testimony regarding a physician's purported negligence or lack thereof only makes matters worse. Because fault is protean, taking on, as it does, different shapes and meanings, establishing fault has also proven to be an untenable criterion for liability in similarly complex cases, such as product liability (defining "defect") or even when dealing with relatively simple and straightforward cases such as auto accidents.<sup>13</sup> But, significantly enough, more than "twice the proportion (11 percent versus 5 percent) of [medical] malpractice suits go to trial" as compared to "other types of personal injury suits (such as motor vehicle or product injuries)."<sup>14</sup>

Determining damages in personal injury cases, especially for pain and suffering, is equally, if not more, troublesome.<sup>15</sup> In most instances of tort loss, relatively accurate markets are available for determining a plaintiff's actual losses in dollars. For instance, a market is available for determining the dollar value of a particular motorcycle damaged in an accident. Likewise, in the case of personal injuries, markets are available for determining economic damages such as wage loss.<sup>16</sup> In the case of pain and suffering and other psychic damages, however, no such markets are available for quantifying loss into a dollar value. In other words, there are no buyers and sellers of pain and suffering; instead, awards are based on highly subjective and differing notions as to the economic value of intangible injury. According to Professor Mark Geistfeld, this leaves jurors to rely solely on their "collective enlightened conscience."<sup>17</sup> The result is that awards for pain and suffering can vary widely for similar injuries. Two similarly

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13 Cf. COMM. FOR ECON. DEV., *BREAKING THE LITIGATION HABIT: ECONOMIC INCENTIVES FOR LEGAL REFORM* 10-11 (2000) ("The substantive law declared by the courts is often complex and . . . defies common sense. The imposition of liability is unpredictable, leading to doubt as to whether justice is served . . .").

14 Paul C. Weiler, *Fixing the Tail: The Place of Malpractice in Health Care Reform*, 47 *RUTGERS L. REV.* 1157, 1163 (1995) (footnote omitted).

15 Jurors sitting on civil cases report that assessing damages is more difficult than resolving the issue of liability. See Mark Geistfeld, *Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries*, 83 *CAL. L. REV.* 773, 783 (1995).

16 See *id.* at 832-35 (discussing a market approach to the determination of personal injuries).

17 *Id.* at 782 (quoting GRAHAM DOUTHWAITE, *JURY INSTRUCTIONS ON DAMAGES IN TORT ACTIONS* § 6-17, at 274 (2d ed. 1988)).

injured plaintiffs suffering from "equally" severe injuries<sup>18</sup> may receive entirely different awards even in the same jurisdiction. Overall, the numerous problems associated with the assessment of pain and suffering, and noneconomic damages in general, led Harvard Law Professor Louis Jaffe to remark long ago in a seminal article that the determination of such damages is an evaluation of the "imponderable" through means of "arbitrary indeterminateness."<sup>19</sup>

In addition to the difficulty and unfairness posed by translating nonpecuniary losses into pecuniary amounts, three major negative consequences arise from such an inquiry. First, arbitrary nonmonetary awards have the effect of undermining deterrence since risk-creating actors who perform cost-benefit analyses find it very difficult to determine whether the costs of prevention are justified in light of the costs of liability (both monetary and nonmonetary) that may arise in the absence of such precautions.<sup>20</sup> Second, unpredictability of nonmonetary damages also makes the prospect of the parties agreeing to a settlement price much more elusive.<sup>21</sup> Lastly, arbitrary nonmonetary awards have the further effect of increasing the price of liability insurance and, even on occasion, threatening the complete withdrawal of insurance coverage for some areas of medical treatment.<sup>22</sup> As Professor Kenneth Abraham puts it in the similar context of product liability:

Ex ante, the prospect of a runaway tort award, even worse of a multiplicity of such awards stemming from a single decision . . . can generate a level of risk aversion among potential defendants and their insurers that is far more costly and economically disruptive than the same tort expenditures made in a more rational and predictable fashion.<sup>23</sup>

With all the difficulties of determining fault and nonpecuniary losses, the tort system represents two unfortunate extremes. At one end, there is an abundance of "false positives," i.e., outcomes when defendants are held responsible for a plaintiff's losses when they

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18 Notice that there is no objective measurement for determining the severity of a plaintiff's pain and suffering. See Jeffrey O'Connell & Geoffrey Paul Eaton, *Binding Early Offers as a Simple, if Second-Best, Alternative to Tort Law*, 78 NEB. L. REV. 858, 862-63 (1999).

19 Louis L. Jaffe, *Damages for Personal Injury: The Impact of Insurance*, LAW & CONTEMP. PROBS., Spring 1953, at 219, 224-25.

20 See Geistfeld, *supra* note 15, at 786-87.

21 See Weiler, *supra* note 14, at 1179.

22 See Geistfeld, *supra* note 15, at 788.

23 *Id.* (quoting Kenneth S. Abraham et al., *Enterprise Responsibility for Personal Injury: Further Reflections*, 30 SAN DIEGO L. REV. 333, 339 (1993)).

should not be.<sup>24</sup> At the opposite end, there are countless cases of "false negatives," i.e., outcomes when defendants are not held responsible for plaintiffs' injuries when they should be.<sup>25</sup> Between these extremes are also the problems of fraud and other chicanery. The impact of fraud and corruption is threefold. First, they can lead to occurrences of false positives, the aggregating effects of which can cripple the tort system. Second, fraud and other corruption can also result in the overcompensation of a plaintiff. For example, since awards for pain and suffering are often roughly calculated as a multiple of medical expenses, the incentive to incur unnecessary medical services (already covered by the claimant's own health insurance) is rampant. In this second situation, even though a defendant should be held liable for a plaintiff's injuries, the defendant—and society—is made to pay more than is necessary to compensate fully the plaintiff. Insurers and consumers are the bearers of those extra costs, in the form of higher premiums and other health care expenses. Finally, the prospect of false negatives encourages defendants to unfairly resist, reduce, and delay payment of deserving claims.

The adjudication of complicated disputes by non-expert judges and juries can add to the problems of the tort system. Triers of fact consist of ordinary laity who can be overwhelmed by complicated fact patterns, conflicting expert testimony and sympathy, and emotion. When such is the case, juries for example, often decide suits—several years after the incident in question—"by the spirit of the law and not by its letter."<sup>26</sup> This generalization is buttressed when one considers the complicated, long-winded nature of jury instructions, often framed in legalese incomprehensible to jurors, formulated more to satisfy appellate courts rather than enlighten jurors.<sup>27</sup> The result is

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24 See Jeffrey O'Connell, *Two-Tier Tort Law: Neo No-Fault & Quasi-Criminal Liability*, 27 WAKE FOREST L. REV. 871, 871 (1992). It is estimated that 25,000 to 30,000 medical tort suits filed each year are invalid. Weiler, *supra* note 14, at 1165.

25 See O'Connell, *supra* note 24, at 871. It is estimated that each year perhaps 75,000 potentially valid claims are not filed or do not lead to awards. Weiler, *supra* note 14, at 1165.

26 HARRY KALVEN, JR. & HANS ZEISEL, *THE AMERICAN JURY* 8 (1966).

27 See generally Robert P. Charrow & Vedar R. Charrow, *Making Legal Language Understandable: A Psycholinguistic Study of Jury Instructions*, 79 COLUM. L. REV. 1306 (1979) (proposing a methodology for measuring comprehensibility of legal language, in particular, jury instructions); Charles T. McCormick, *Jury Verdicts Upon Special Questions in Civil Cases*, 2 F.R.D. 176, 177 (1941) (calling for reform of juries and jury instructions).



that, in Jerome Frank's telling phrase, many jury findings are an exercise in "juriesprudence" not "jurisprudence."<sup>28</sup>

Turning to the substance of this Article, Part I of this Article summarizes the duty of care standard applied to physicians. Part II summarizes those standards as applied much more leniently to corporate officers and directors under the business judgment rule. Part III contains systematic responses to the seven arguments most often proposed as to why a difference in legal liability attaches for physicians as opposed to corporate officers and directors. Part IV summarizes an early offers plan and explains the improvements it makes over the existing tort system. Finally, the Appendix focuses on the "tools" of the early offers approach and examines whether jurors will be able to distinguish between the early offers plan and the ordinary tort system.

Before presenting the following proposal for applying a variation of the business judgment rule to medical malpractice law, let it be said that in doing so we undertake a very extensive description and comparison of both medical malpractice law and the business judgment rule. All these legal niceties are presented in deference to the maxim that "'God' is in the details" and seem suitable for a law review article. But legal analyses are often overly complex and subject to abstruse parsing. Our basic point—which we hope will peer through all the particulars and will be kept in mind by the reader throughout—is that regardless of the precise suitability of an exhaustive juxtaposition of medical malpractice law and the business judgment rule, the essential validity will be seen of freeing most medical malpractice claims (and indeed other personal injury cases as well) from the tortuous, even torturous tangle, of tortious liability in a manner analogous to that achieved for corporate officers and directors under the business judgment rule.

## I. DUTY OF CARE STANDARD FOR PHYSICIANS

Our presentation of a detailed comparison of the duty of care standard as applied to physicians, as opposed to corporate officers and directors, is based heavily on an article entitled *Medical Malpractice v. the Business Judgment Rule: Differences in Hindsight Bias* by Hal Arkes and Cindy Schipani.<sup>29</sup> To begin with, their article contains a discussion of

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28 Maurice Rosenberg, *Contemporary Litigation in the United States*, in LEGAL INSTITUTIONS TODAY 152, 177–78 (Harry Jones ed., 1977). But see *infra* notes 293–300 and accompanying text.

29 Hal R. Arkes & Cindy A. Schipani, *Medical Malpractice v. the Business Judgment Rule: Differences in Hindsight Bias*, 73 OR. L. REV. 587 (1994). Hal R. Arkes is a Professor of Psychology at Ohio University, and Cindy A. Schipani is a Professor (an Associ-

health care providers' duty of care that is thorough and accurate enough to make it unnecessary for us to reinvent this particular wheel.<sup>30</sup> That said, our summary of the duty of care standards for physicians and corporate officers and directors serves to lay the groundwork for an extensive analysis of the different legal standards exacted from health care providers versus corporate officers and directors.

The existence of a physician-patient relationship establishes a duty on the part of a physician to adhere to certain acceptable standards of medicine in the treatment of a patient. Obviously, physicians are not held strictly liable for their actions; that is, they are not held to be insurers of a beneficial outcome.<sup>31</sup> Instead, physicians are measured against an objective standard of care that calls for physicians to possess and apply the degree of skill and knowledge ordinarily held by average members of the profession in good standing.<sup>32</sup> Inherent in this standard is the proposition that physicians are expected to "keep up to date and abreast of changes[,] . . . to take a careful history, perform a careful examination, function within the confines of the physician's learning and capability, arrive at appropriate diagnosis, prescribe and implement appropriate therapies, and refer for appropriate consultation when indicated."<sup>33</sup> Physicians are held liable for a patient's injuries when the occurrence of harm is attributable to a physician's "want of the requisite skill and knowledge, or the omission to exercise reasonable care, or the failure to use [one's] best judgment."<sup>34</sup> Other than these oft-repeated principles, however, many variables exist concerning due care standards. For instance, due care standards may be defined by references to local community standards, may allow physicians to rely on custom, or may require them to allow patients to exercise informed consent.<sup>35</sup>

Historically, a physician's conduct was measured and judged by the prevailing level of care practiced in the defendant's community. This strict locality rule originated in response to the perceived inequity in holding rural physicians to the same standards expected of ur-

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ate Professor at the time of the publication of the above mentioned article) at the School of Business Administration at the University of Michigan.

30 *Id.* at 594-95.

31 *Id.*

32 *Id.*

33 STEVEN E. PEGALIS & HARVEY F. WACHSMAN, *AMERICAN LAW OF MEDICAL MALPRACTICE* § 3.2, at 97 (2d ed. 1992).

34 Arkes & Schipani, *supra* note 29, at 596 (quoting *Pike v. Honsinger*, 49 N.E. 760, 762 (N.Y. 1898)).

35 *See id.* at 595.

ban practitioners who possessed greater resources and access to information.<sup>36</sup> However, unwillingness on the part of physicians to testify against colleagues practicing in the same community created serious evidentiary problems for plaintiffs.<sup>37</sup> As a result, and for other reasons as well,<sup>38</sup> many states modified their strict locality rule in favor of either a "national standard" or a "similar community standard."<sup>39</sup> Additionally, physicians who hold them themselves out to be specialists in a particular area of medicine are also expected to possess the same skill and knowledge common of competent specialists in their field.<sup>40</sup> So, a national standard is considered by most courts to apply to specialists' standard of care.<sup>41</sup>

Unlike ordinary negligence claims, "courts almost exclusively defer to the customary practice of the [medical] profession"<sup>42</sup> because of the high level of expertise possessed by physicians. Furthermore, subject to certain quality assurances, physicians, for the most part, set their own standard of care.<sup>43</sup> Therefore, rather than directly inquiring into the physicians conduct for reasonableness, courts are apt to focus their examination of a medical malpractice case on whether a defendant departed from the level of care other physicians in good standing would have utilized under like circumstances.<sup>44</sup> The reason for this approach lies not only in the reluctance to allow the laity to second guess health care professionals, but also in the corollary assumption that physicians who provide care consistent with what is customary have presumably not acted unreasonably or imprudently.<sup>45</sup>

The testimony of other physicians—expert testimony—must ordinarily be presented by the plaintiff to show a deviation from recognized standards.<sup>46</sup> Yet, a physician's adherence to custom does not necessarily shield one from liability. Some courts refuse to consider

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36 See *id.* at 603.

37 See *id.* at 603–04.

38 Other reasons for the abandonment of the strict locality rule include the fear that rural patients would receive a substandard level of medical treatment, the standardization and nationalization of medical education, the nationalization of medical journals, the availability of modern transportation and communication, and the availability of physician referrals. See *id.* at 604.

39 See *id.*

40 See *id.* at 605.

41 See *id.*

42 *Id.* at 597.

43 *Id.* at 598.

44 See *id.*

45 See *id.*

46 See *id.*

custom dispositive of the question of liability.<sup>47</sup> That is, physicians may not entirely limit their "responsibility to the skill and knowledge characteristic of the norm."<sup>48</sup> Thus, a plaintiff may still make a *prima facie* case for medical malpractice—despite a physician's adherence to custom—if a physician in using the knowledge and skills possessed nevertheless fails to satisfy the trier of fact that he or she behaved as a reasonably prudent physician. At the other end, courts have traditionally not penalized physicians who have departed from customary practices when evidence exists to show that "new medical techniques are better than old ones, where a respectable minority of the profession follow an alternative practice, or where the customs become outdated or inadequate."<sup>49</sup>

With this admittedly quick summary of the medical standard of care, we next examine duty of care standards for corporate officers and directors.

## II. DUTY OF CARE STANDARD FOR CORPORATE OFFICERS AND DIRECTORS

A director's duty of care has also been expressed in terms of the "reasonably prudent" standard, a hypothetical construct that also lies at the heart of tort law in general. According to the *Revised Model Business Corporation Act*, which has been adopted in many states,<sup>50</sup> a

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<sup>47</sup> See *id.* at 600.

<sup>48</sup> *Id.* at 599.

<sup>49</sup> *Id.* (citations omitted). The so-called "best judgment" rule (of which more below) is also a criterion in some jurisdictions for a physician's compliance with due care standards. *Id.* at 601. The best judgment rule is seen as creating tension in determining malpractice and leaves room for confusion in the formulation of jury instructions. *Id.* For instance, it is argued that it is possible for physicians to exercise their best judgment yet still decide on a course of treatment that would not have been chosen by competent members of the physician's medical community (whether based on a "similar community" or "national community" standard). *Id.* Under such a situation, it is argued physicians' use of their best judgment is not—nor should it be misunderstood by a trier of fact to be—a sufficient defense against evidence of incompetence. *Id.* at 603. Because of the concern of jury confusion, courts have shifted toward eliminating the best judgment (or "error of judgment") standard. *Id.* at 602 & n.62 (citing *Shumaker v. Johnson*, 571 So. 2d 991, 994 (Ala. 1990); *Ouellette v. Subak*, 391 N.W.2d 810, 815 (Minn. 1986); *Shamburger v. Behrens*, 380 N.W.2d 659, 663 (S.D. 1986); *Wall v. Stout*, 311 S.E.2d 571, 577 (N.C. 1984); *Teh Len Chu v. Fairfax Emergency Med. Ass'n*, 290 S.E.2d 820, 822 (Va. 1982)). But see *infra* notes 240–44 and accompanying text.

<sup>50</sup> Twenty-four states have adopted all or substantially all of the *Model Business Corporation Act* (the *Model Act*) as their general corporation statute. REV. MODEL BUS. CORP. ACT, Introduction, at xix (1999). These states are: Alabama, Arizona, Arkansas, Connecticut, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, Montana,

director is required to discharge his/her duties "(1) in good faith, and (2) in manner the director reasonably believes to be in the best interests of the corporation . . . [and] with the care that a person in a like position would reasonably believe appropriate under similar circumstances."<sup>51</sup> Likewise, The American Law Institute's *Principles of Corporate Governance and Structure: Analysis and Recommendation* defines a director's duty in similar terms.<sup>52</sup> Under the common law, the variations in the duty of care standard range from requiring corporate officers and directors to exercise the care expected of ordinarily prudent persons in like circumstances in the conduct of their own affairs, to employing only the degree of care necessary to avoid gross negligence.<sup>53</sup> In other words, courts have turned to concepts of both ordinary (i.e., simple) negligence and gross negligence in resolving the requisite degree of care.

Note, however, a director's duty of care is not identical in the decisionmaking and non-decisionmaking context (i.e., oversight). In the decisionmaking context, the business judgment rule acts as a qualification on the statutory duty of care.<sup>54</sup> The business judgment rule

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Nebraska, New Hampshire, North Carolina, Oregon, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming. *Id.* at xix n.1. Seven other jurisdictions have corporation statutes based on the 1969 version of the *Model Act*. *Id.* at xix. These seven jurisdictions are: Alaska, the District of Columbia, Hawaii, Maine, New Mexico, Rhode Island, and South Dakota. *Id.* at xix n.2.

51 *Id.* § 8.30(a), (b). The *Model Act's* 1984 formulation of the duty of care provided that a director is required to discharge his/her duties with "the care an ordinarily prudent person in a like position would exercise under similar circumstances." *Id.* § 8.30.

52 Specifically, duty of care is defined as "the care that an ordinarily prudent person would reasonably be expected to exercise in a like position and under similar circumstances." AM. LAW INST., *PRINCIPLES OF CORPORATE GOVERNANCE AND STRUCTURE: ANALYSIS AND RECOMMENDATIONS* § 4.01(a) (1994) [hereinafter *PRINCIPLES OF CORPORATE GOVERNANCE*].

53 See Arkes & Schipani, *supra* note 29, at 611.

54 See Charles Hansen, *The ALI Corporate Governance Project: Of the Duty of Due Care and the Business Judgment Rule, a Commentary*, 41 BUS. LAW. 1237, 1240 (1986) [hereinafter Hansen, *ALI Corporate Governance Project*]. In the non-decisionmaking context, the test of liability is "some form of results oriented due care standard that measures the merits of the directors' supervisory performance." Charles Hansen, *The Duty of Care, the Business Judgment Rule, and the American Law Institute Corporate Governance Project*, 48 BUS. LAW. 1355, 1356 (1993) [hereinafter Hansen, *The Duty of Care*]. As we shall see, in the non-decisionmaking context, the required due care standard is much less demanding than the traditional language often expressed in case law, or in the *Model Act* or in the *Principles of Corporate Governance*. See Hansen, *The Duty of Care, supra*, at 1359. (By way of illustration, the REV. MODEL BUS. CORP. ACT § 8.30 (1984) speaks of due care in terms of "the care an ordinarily prudent person in a like position would exercise under similar circumstances.").

provides that if in the course of management, officers and directors arrive at a decision that is within their and the corporation's authority, and for which there is a rational basis, "*and they act in good faith, as the result of their independent discretion and judgment, and uninfluenced by any consideration other than what they honestly believe to be in the best interests of the corporation,*" then a court will not second guess the judgment of the officers and/or directors; nor will a court "enjoin or set aside [a] transaction or . . . surcharge the directors [and officers] for any resulting loss."<sup>55</sup> Therefore, assuming that the above criteria are satisfied, the business judgment rule greatly restricts the duty of care in the decisionmaking context to the use of appropriate procedures or processes as the applicable test. In large measure, liability does not exist for questionable substantive decisions regardless of whether they are mistakes of judgment or controversial business decisions.<sup>56</sup>

That having been said, however, clearly not all business decisions come under the umbrella of the business judgment rule. Courts have held uniformly that conduct that is irrational or egregious in nature is not protected by the business judgment rule.<sup>57</sup> They have described the egregious conduct exception in a number of ways, such as "so unwise or unreasonable as to fall outside the permissible bounds of the

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As one commentator has noted, despite the traditional language used, a careful examination of the facts and holdings of cases indicate that officers and directors are found liable in the non-decisionmaking context "only upon an express abdication of responsibility or upon obvious and prolonged failure to exercise oversight or supervision." Hansen, *The Duty of Care*, *supra*, at 1359. In other words, *only* when there is an abdication of responsibility by officers and directors do courts impose liability. An often-cited case demonstrating this observation is *Francis v. United Jersey Bank*, 432 A.2d 814 (N.J. 1981). In *Francis*, a director of a reinsurance brokerage was held personally liable for unlawful payments made by her sons as officers of the corporation because of her neglect of corporate affairs. The New Jersey Supreme Court found that the director never read or obtained the firm's financial statements, which would have plainly revealed the fraud, nor did she know virtually anything of the corporation's affairs. 432 A.2d at 819. According to Charles Hansen, "[a]n extensive study of the cases in the non-decision making context indicates that express abandonment of duty, or patterns of exacerbated neglect amounting to an abandonment of duty, constitute, with rare exception, the only circumstances in which directors were found liable" despite talk of traditional tort-derived formulations of the duty of care. Hansen, *The Duty of Care*, *supra*, at 1360. Thus, the similarity of language defining due care standards for physicians and corporate officers and directors is highly deceptive.

55 HARRY G. HENN & JOHN R. ALEXANDER, *LAWS OF CORPORATIONS* 661 (3d ed. 1983) (citations omitted) (emphasis added).

56 See Hansen, *The Duty of Care*, *supra* note 54, at 1357.

57 *Id.* at 1358.

directors' sound discretion,"<sup>58</sup> "an abuse of discretion,"<sup>59</sup> "egregious or irrational,"<sup>60</sup> and "reckless indifference to or a deliberate disregard of the stockholders."<sup>61</sup> Generally, such conduct is treated by the courts as negating the good faith element of the business judgment rule.<sup>62</sup> Furthermore, courts have held that corporate waste, or board action that is illegal or fraudulent on the part of directors, or decisions that are made *ultra vires* are also outside the protection of the business judgment rule.<sup>63</sup>

The broad interpretation that courts have fastened to this doctrine,<sup>64</sup> and the fact that officers and directors are not held to a standard of simple negligence,<sup>65</sup> is done to preserve the autonomy and decisionmaking independence of corporate America. It has been only in the rarest and most extreme cases that officers and directors have been held unable to satisfy the lenient standard imposed by the business judgment rule. According to the American Law Institute, the twentieth century has produced roughly only forty cases—notwithstanding the duty of care standard—where directors have been held liable under the business judgment rule.<sup>66</sup> The late Yale University Professor Joseph Bishop, writing in the latter 1960s, described his search for cases imposing liability on directors for ordinary negligence, uncomplicated by self-dealing, as searching for "a very small

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58 *Id.* (citing *Cramer v. Gen. Tel. & Elecs. Corp.*, 582 F.2d 259, 275 (2d Cir. 1979)).

59 *Id.* (citing *Aronson v. Lewis*, 473 A.2d 805, 812 n.6, 815 (Del. 1984)).

60 *Id.* (citing *Citron v. Fairchild Camera & Instrument Corp.*, No. 6085, slip op. at 45 (Del. Ch. May 19, 1988), *aff'd*, 569 A.2d 53 (Del. 1989)).

61 *Id.* at 1366 (citing *Allaun v. Consol. Oil Co.*, 147 A. 257, 261 (Del. Ch. 1929)).

62 *Id.* at 1358.

63 *Id.* at 1365–69.

64 One of the most famous formulations of the business judgment rule, typical of the broad interpretation that courts have attached to this doctrine, is found in *Aronson v. Lewis*, 473 A.2d 805, 812 (Del. 1984) (stating that "[i]t is a presumption that in making a business decision the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interests of the company").

65 There are a few jurisdictions that do hold officers and directors to the standard of simple negligence. *E.g.*, *Theriot v. Bourg*, 691 So. 2d 213 (La. Ct. App. 1997) (stating that in Louisiana the standard of care is simple rather than gross negligence). These jurisdictions remain a small minority, and they have received wide criticism for their interpretation of the business judgment rule. *See, e.g.*, Thomas M. McEachin, Note, *Theriot v. Bourg: The Demise of the Business Judgment Rule in Louisiana?*, 59 LA. L. REV. 375 (1998).

66 PRINCIPLES OF CORPORATE GOVERNANCE, *supra* note 52, § 4.01(a) cmt. h.

number of needles in a very large haystack."<sup>67</sup> Another commentator has remarked that his efforts in finding such cases have been a "relatively fruitless search."<sup>68</sup> Therefore, the existence of the business judgment rule has served as an effective means to limit what is often deemed fruitless and wasteful litigation and to curb liability as to decisions of corporate officers and directors. Suits by shareholders for securities fraud are covered under different laws that are irrelevant for our present purposes since health care providers do not normally face suits based on fraud.

Over and above the business judgment rule, forty-six jurisdictions have also enacted legislation that allows corporations to immunize officers and directors from personal economic liability to both the corporation and its shareholders for breaches of duty of care.<sup>69</sup> With the exception of improper payments of dividends, all these statutes allow for corporations to release directors from liability for acts of simple negligence and most permit exoneration for even acts of gross negligence.<sup>70</sup> Therefore, regardless of a jurisdiction's conception of the business judgment rule, nearly all state legislatures have delegated the issue of ultimate liability to each individual corporation. Corporations are free to decide for themselves whether they wish to provide for the exculpation and/or indemnification of their officers and directors should they be found to have violated their duty of care as defined by simple or even gross negligence standards.<sup>71</sup>

Policy rationales invoked as a basis for justifying the business judgment rule and insulating directors from liability are well-settled in American corporate jurisprudence. Frequently it is emphasized that courts lack the sagacity and expertise necessary to justify the substitution of their business acumen for that of officers and directors.<sup>72</sup> It is often said that corporate America cannot "risk . . . permitting or re-

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67 Joseph W. Bishop, Jr., *Sitting Ducks and Decoy Ducks: New Trends in the Indemnification of Corporate Directors and Officers*, 77 YALE L.J. 1078, 1099 (1968).

68 Hansen, *ALI Corporate Governance Project*, *supra* note 54, at 1245.

69 See Arkes & Schipani, *supra* note 29, at 617; see also, e.g., DEL CODE ANN. tit. 8, § 102(b)(7) (Supp. 2000).

70 See Arkes & Schipani, *supra* note 29, at 617-18.

71 Notice that with the existence of exculpation and/or indemnification it is unnecessary for officers and directors to allocate a portion of their salaries to the purchasing of costly malpractice insurance.

72 See Daniel R. Fischel, *The Corporate Governance Movement*, 35 VAND. L. REV. 1259, 1288 (1982) ("Courts . . . do not possess the experience, expertise, or information necessary to make complicated business decisions."); see also E. Norman Veasey, *Seeking a Safe Harbor from Judicial Scrutiny of Directors' Business Decisions—An Analytical Framework for Litigation Strategy and Counselling Directors*, 37 BUS. LAW. 1247, 1265-66 (1982).



quiring . . . courts to become, in effect, appellate boards of directors.”<sup>73</sup> It is also often asserted that the business judgment rule is necessary to encourage qualified men and women to serve as corporate officers and directors, and to motivate such persons to take entrepreneurial risks.<sup>74</sup>

Actually, there exists a plethora of possible explanations—many of which are permutations of one another—as to why courts continue to adhere to this rule. According to Professor Franklin Gevurtz, such rationales ultimately fall into four general categories,<sup>75</sup> whereas Dean Kenneth Davis of the University of Wisconsin Law School concentrates on five possible explanations for justifying the business judgment rule and the manner in which courts have responded to duty of care in the business context.<sup>76</sup> As will be shown in greater detail in the ensuing section, the problem with these categories, however, is not that they necessarily lack validity, but rather that, as Professor Gevurtz puts it,

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<sup>73</sup> R. Franklin Balotti & James J. Hanks, Jr., *Rejudging the Business Judgment Rule*, 48 BUS. LAW. 1337, 1341–42 (1993) (citation omitted).

<sup>74</sup> *Id.* at 1342.

<sup>75</sup> Franklin A. Gevurtz, *The Business Judgment Rule: Meaningless Verbiage or Misguided Notion?*, 67 S. CAL. L. REV. 287, 304–21 (1994) (stating that the four general categories are: difficulties with after-the-fact review of business decisions, nature of the damages, nature of the plaintiff, and utility of compensation or deterrence).

<sup>76</sup> Kenneth B. Davis, Jr., *Once More, the Business Judgment Rule*, 2000 WIS. L. REV. 573, 574–75, 580–89 (explaining the business judgment rule in terms of risk allocation (weak and strong form), expertise, imperfect litigation, non-standardization and sovereignty). The weak form of the risk allocation rationale provides that business decisions and risks are inseparable, and that sound decisions when made, although later resulting in loss, should not, with the prescriptive of hindsight, result in personal liability for corporate officers and directors. According to this view, the business judgment rule is needed in order to ensure healthy risk taking in the business context. *Id.* at 574. The strong form of the risk allocation rationale provides that the business judgment rule is necessary for purposes of risk distribution. This justification sees the business judgment rule as a necessary tool to shift loss from a small group (such as a board) across a larger, more diversified group (such as shareholders). *See id.* at 575. The expertise rationale provides that business judgments should be for business experts, such as directors and management, and that judges and juries are ill-equipped to review such decisions. *See id.* at 580. The imperfect litigation rationale provides that litigation, several years after the action in question, cannot fairly evaluate all the circumstances and factors confronting corporate officers and directors when their decision was made. *See id.* The standardization rationale provides that corporate officers and directors, as a profession, lack institutional arrangements to “develop, debate, and disseminate professional standards.” *Id.* at 583. Finally, the sovereignty rationale justifies the business judgment rule on the grounds that there exists a statutory directive (at least in states like Delaware) that “the corporation’s business and affairs be managed by or under the direction of its board of directors” not courts. *Id.* at 587; *see also infra* notes 215–21 and accompanying text.

they "prove too much [since] they could apply with equal force to numerous other situations in which the rule of ordinary negligence commonly applies."<sup>77</sup> This was precisely the reasoning behind the court's decision in *Currie v. United States*, where the court juxtaposed a business decision to that of a psychotherapist's and found that in both areas it was unsuited to review the judgment of the professional.<sup>78</sup> Specifically, the court held that

In the business judgment rule, courts defer to the decisions of disinterested directors absent bad faith or self-interest. *Many of the considerations cited as justifications for the business judgment rule are applicable to the present case.* For example, as with business decisions, the court is not particularly qualified to review commitment decisions involving mental health and dangerousness. In addition, these types of commitment procedures require quick action, and "after the fact litigation is a most imperfect device to evaluate" those decisions, as in the corporate setting . . . . Finally, policy considerations favor giving psychotherapists, as well as corporate directors, significant discretion to use their best judgment, recognizing that "a rule which penalizes the choice of seemingly riskier alternatives . . . may not be in the interest" of the parties or society.<sup>79</sup>

Accordingly, the court in *Currie* held that a psychotherapist judgment rule, similar to the business judgment rule, should be recognized. Under the psychotherapist judgment rule then, simple errors in judgment on the part of a therapist would not be sufficient for the imposition of liability.<sup>80</sup> Instead, courts would be expected to inquire into the "good faith, independence and thoroughness" of a therapist's decision not to commit a patient.<sup>81</sup> Factors that the court should consider in making an assessment as to the presence of good faith include: a therapist's competence and training; a therapist's review of relevant documents and evidence in an adequate, prompt, and independent manner; a therapist's receipt of advice or opinion from an

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<sup>77</sup> Gevurtz, *supra* note 75, at 305–12 (arguing that the business judgment rule should be abolished and that corporate officers and directors should be held to the same rules of simple negligence as is the case with other professionals). In his article, Professor Gevurtz advanced several of the arguments generated in this Article. Unlike Professor Gevurtz, however, we do not believe that such arguments should be used to abolish the business judgment rule. Instead, the arguments extended by Professor Gevurtz should be utilized to expand at least a variant of the business judgment rule to other professions such as medicine and engineering and even beyond. See *infra* notes 250–55 and accompanying text.

<sup>78</sup> 644 F. Supp. 1074, 1083 (M.D.N.C. 1986), *aff'd*, 836 F.2d 209 (4th Cir. 1987).

<sup>79</sup> *Id.* (citations omitted) (emphasis added).

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

other therapist; consideration as to whether the evaluation was made in light of proper legal standards of commitment; and existence of other evidence of good faith.<sup>82</sup>

Likewise in *Littleton v. Good Samaritan Hospital & Health Center*, the Ohio Supreme Court, relying heavily on *Currie* and the precedence of New York decisions, adopted a professional judgment rule.<sup>83</sup> Specifically, the court held that “[c]ourts, with the benefit of hindsight, should not be allowed to second-guess a psychiatrist’s professional judgment.”<sup>84</sup> As Arkes and Schipani acknowledge, “*It is curious that courts do not similarly hesitate to substitute their judgment for the judgment of [other] physicians.*”<sup>85</sup> The next Section explores this topic in greater detail.

### III. RATIONALES TO JUSTIFY DIFFERENCES IN LIABILITY FOR PHYSICIANS AND CORPORATE OFFICERS AND DIRECTORS

Having already discussed the duty of care standards that are imposed on corporate officers and directors as opposed to physicians, the next step is to determine what, if any, rationales can in fact justify the differences in legal liability existing for these two activities. Professors Arkes and Schipani have extensively tackled the same questions that we explore in this Article. The initial thrust of their article—up to the section entitled “Differences in the Medical and Business Standards of Care”<sup>86</sup>—seems to suggest that they would recommend health care professionals be afforded the same deference as corporate officers and directors. Instead, however, after several pages of accurately delineating the disparate treatment that exists between physicians and corporate officers and directors, Arkes and Schipani surprisingly reach the conclusion that “there are legitimate reasons why the standard of care in business and medicine ought to differ, and thus any contemplated reform should not attempt to make the standards identical.”<sup>87</sup>

Although several of the arguments made by Arkes and Schipani may appear persuasive at first blush, a more thorough analysis reveals that their reasoning is insufficient to justify the differences in legal treatment. Accordingly, we challenge the conclusion that differences in legal liability for physicians and corporate officers and directors

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82 *Id.*

83 529 N.E.2d 449, 459 (Ohio 1988).

84 *Id.* at 459–60.

85 Arkes & Schipani, *supra* note 29, at 622 (emphasis added).

86 *See id.* at 621–30.

87 *Id.* at 630.

should necessarily continue. We also regard the bifurcated trial procedure, a reform strategy advanced by Arkes and Schipani,<sup>88</sup> as an ineffective vehicle to combat the dramatic expansion materializing in medical malpractice litigation. Instead, we advocate the implementation of an "early offers" plan, which, as will be explained, contains a variant of the business judgment rule, as an effective reform.

### A. *Role of Risk Taking and Failures*

In their article, Arkes and Schipani provide not four or even five, but seven possible explanations of why there exists a difference in legal treatment for physicians, and corporate officers and directors. First, Arkes and Schipani observe that heightened scrutiny of business outcomes would result in corporate officials becoming risk averse in their decisionmaking capacities.<sup>89</sup> They contend that such proclivity would "lessen the corporate official's willingness to cause their corporations to enter new markets, to develop new products and to take other rational business risks."<sup>90</sup> But why doesn't the same observation apply to physicians and other health care professionals? Note that, as one court put it, limitations on medical malpractice liability seek to "encourage self-reliant [physicians] to whom patients may safely entrust their bodies, and not [ones] who may be tempted to shirk from duty for fear of a lawsuit."<sup>91</sup>

According to Arkes and Schipani, however, risk taking should not be accepted in the medical context whereas in the business context risk taking should "not only [be] expected, but explicitly encouraged."<sup>92</sup> It seems odd to suggest that risk taking is unacceptable in the medical field. Risk taking is very much alive in the field of medicine.<sup>93</sup> In fact, accompanying the increased effectiveness of highly technical modern medicine has been a corollary of the possibility of complications and patient injury during the course of new treatment.<sup>94</sup> Moreover, because—biologically speaking—humans are such highly complicated creatures with intricate systems that respond differently to any given treatment, it must be recognized that risk taking

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88 See *id.* at 633–35.

89 *Id.* at 623.

90 *Id.* (citation omitted).

91 *Barnett v. Bachrach*, 34 A.2d 626, 629 (D.C. 1943).

92 Arkes & Schipani, *supra* note 29, at 623 (citation omitted).

93 See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 185–93 (5th ed. 1984).

94 Robert H. Brook et al., *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197, 1209.

can never be eliminated from any medical decision, even when dealing with choices for relatively innocuous forms of treatment.

Furthermore, oftentimes physicians are required to make split-second decisions as to a particular course of treatment due to complications that may cause the life or well-being of their patient to hang in the balance. Such circumstances not only arise in the emergency room; rather, they remain a very real—and perhaps even a common—feature of any surgical or other invasive procedure. When such a situation presents itself, a physician's decision often involves substantial risk regardless of the course of treatment selected. It is unreasonable to recommend that physicians should avoid high-risk, but necessary, medical intervention because, after all, doing nothing (or avoiding high-risk but necessary procedures) is itself a decision that will often produce unacceptable consequences. Thus, there are times when almost any reasonable decision still involves substantial risks, making risk taking—and perhaps even unfavorable outcomes—inescapable.

Hence, Arkes and Schipani can be challenged when they state that “[u]nlike the situation in medicine, risk-taking in business is not only expected, but explicitly encouraged.”<sup>95</sup> A more accurate statement might well be that, like the situation in business, risk taking in medicine is expected, but unlike corporate officers and directors, medical professionals are not free under present law to choose or be explicitly encouraged to take risks, even though risk taking is an inevitable and unavoidable component of their jobs.

In almost any medical decision a physician must consider at least several factors: the magnitude of the risk of the medical procedure; the benefit of performing the medical procedure (i.e., action); and the magnitude of the risk and the consequences of not performing the medical procedure (i.e., inaction). Regardless of a physician's decision, both treatment and medical passivity involve certain degrees of risk that require a balancing of such factors. It is true that patients should (supposedly anyway) have the final say as to whether or not they are willing to undertake a recognizable or unrecognizable medical risk,<sup>96</sup> but as Professor Franklin Gevurtz points out, “[o]ne cannot find cases . . . in which doctors have been able to use their patients' consent to prevent liability for an unreasonable choice of treatment.”<sup>97</sup> Instead, patients who have suffered harm as a result of ar-

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95 Arkes & Schipani, *supra* note 29, at 623 (citation omitted) (emphasis added).

96 See Gevurtz, *supra* note 75, at 311 & n.107 (citing *Crain v. Allison*, 443 A.2d 558, 561 (D.C. 1982)).

97 *Id.* at 311.

guably reasonable treatment have relied on lack of informed consent as an independent basis for recovery.<sup>98</sup>

Professor Gevurtz goes on to say,

Nor is it realistic to suggest that professionals can use the consent process to avoid exercising any judgment by laying out all the options and all the relevant learning about each option and then letting the patient . . . play doctor . . . . The patient . . . typically wants a recommendation—that is what one employs the professional for. This is why the cases speak of informed consent—consent to a recommended procedure—rather than informed selection of a procedure by the patient.<sup>99</sup>

Accordingly, because physicians must balance the above factors in making their recommendation, a cost-benefit analysis can be formulated in the following terms: If the differential in value between treatment (acting) and medical passivity (not acting) does not cause a substantial benefit, and if the physician recommends treatment, then the treatment was unreasonable and the physician can be considered negligent. If, on the other hand, the potential benefits of the treatment outweigh both the risk involved and the consequences of medical passivity and the physician recommends treatment, then it would seem that the physician acted reasonably and therefore was not negligent.<sup>100</sup> It thus seems fallacious to attempt to justify the difference in legal treatment between physicians and corporate officers and directors on the grounds that a higher standard of care imposed on physicians compels them not to take unnecessary risks. Either way, risks are unavoidable and the existence of a higher standard of care does not necessarily induce physicians to avoid “failure.”

Earlier we quoted Arkes and Schipani’s contention that a deviation from the business judgment rule as applied to officers and directors, “would discourage managerial risk-taking and . . . lessen the corporate official’s willingness to cause their corporations to enter

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98 *Id.*

99 *Id.* at 311 n.110.

100 See *Eckert v. Long Island R.R.*, 43 N.Y. 502 (1871) (upholding a jury verdict finding that a deceased killed while attempting to rescue a child from the path of an oncoming train was not negligent). The *Eckert* court explained, “If, from the appearances, he [the deceased] believed that he could [save the child], it was not negligence to make an attempt so to do, although believing that possibly he might fail and receive an injury himself.” *Id.* at 505–06. The court continued, “The law has so high a regard for human life that it will not impute negligence to an effort to preserve it, unless made under such circumstances as to constitute rashness in the judgment of prudent persons.” *Id.* at 506. In other words, if the potential benefits of the action outweigh both the risk involved and the consequences of not acting, then a defendant is not negligent (nor a plaintiff contributorily negligent) for so acting.

new markets, to develop new products and to take other rational business risks."<sup>101</sup> To the extent true,<sup>102</sup> one can just as persuasively argue that the negligence standard imposed on health care professionals equally lessens physicians' willingness to perform difficult and high-risk procedures.<sup>103</sup> This would be especially true in terms of a cost-benefit analysis if, as often seems likely, the potential costs of liability for difficult and high-risk procedures far exceed the monetary benefits gained for such medical services rendered. The existence of the negligence standard in the medical profession may especially induce physicians to avoid high-risk patients and fail to aggressively pursue new courses of treatment—whether procedure or drug—that have yet to receive wide acceptance in the medical community. Therefore, although medical researchers may be moving the medical profession to the vanguard of new approaches to healing, clinicians' trepidation concerning liability could result in a backlash that may delay the implementation of newly uncovered treatments in the practice setting. The result is that researchers and clinicians may be functioning at highly dissimilar paces, with some clinicians remaining behind the progress of researchers at a rate that is deleterious to patients.<sup>104</sup>

Consequently, fear of liability can result in overdeterrence, which is oftentimes referred to as defensive medicine. Granted, all the difficulties of defining defensive medicine, many, if not most, physicians seem to engage in it.<sup>105</sup> A 1986 American Medical Association (AMA) survey found that seventy-eight percent of physicians believed they practiced defensive medicine.<sup>106</sup> That is, in an effort to shield them-

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101 Arkes & Schipani, *supra* note 29, at 623.

102 Note the caveat that this observation is most true if a corporation has not adopted any exculpatory or indemnifying provisions that shield its officers and directors from liability.

103 See Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, LAW & CONTEMP. PROBS., Spring 1986, at 321, 324; Brook et al., *supra* note 94, at 1213, 1217; James W. Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctors [sic] View*, 6 WILLAMETTE L.J. 225, 231 (1970); Gevurtz, *supra* note 75, at 312 & n.113 (citing STAFF OF SENATE SUBCOMM. ON EXECUTIVE REORGANIZATIONS OF THE SENATE COMM. ON GOV'T OPERATIONS, 91ST CONG., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 453 (Comm. Print 1969)).

104 The problem is that fear of liability can cause practitioners to resist many of the new advances made by researchers and therefore cause an unnecessary delay between discovery and implementation. Cf. Peter W. Huber, *Safety and the Second Best: The Hazards of Public Risk Management in the Courts*, 85 COLUM. L. REV. 277, 308-09 (1985).

105 See M. Schwarz, *Liability Crisis: The Physicians' Viewpoint*, in MEDICAL MALPRACTICE—TORT REFORM 18 (James E. Hamner & B.R. Jennings eds., 1987) (citing L. HARVEY & S. SHUBAT, A.M.A. SURVEYS OF PHYSICIANS AND PUBLIC OPINION (1986)).

106 See *id.* at 20.

selves from even a distant possibility of a "false positive"—an unwarranted finding of liability—physicians often rely upon unnecessary and precautionary tests and procedures that are justified by legal rather than medical rationales.<sup>107</sup> The effect is that the AMA has estimated that over \$15 billion dollars per year is spent on defensive medicine.<sup>108</sup> A more recent study concentrating on defensive medicine suggests that national tort reform lessening defensive medicine could generate \$50 billion in savings annually without jeopardizing quality health care.<sup>109</sup>

Moreover, the difference in the nature of damages between poor business and medical decisions does not seem a bona fide reason to explain the difference in legal treatment that exists between corporate and medical personnel. There is no dispute that poor business decisions often result in only monetary loss, whereas errors in medical decisions result in physical injury. But it would appear that this difference in the nature of damages does not explain why the law holds officers and directors, as opposed to medical professionals, to dissimilar standards of care. If in fact the nature of damages was sufficient<sup>110</sup> to explain the different standard of liability for officers and directors as opposed to physicians, then attorneys<sup>111</sup> and accountants likewise would fall under the protection of a standard of care similar to officers and directors.<sup>112</sup> In other words, it seems odd to contend that the difference in the nature of damages is a legitimate justification for

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107 See U.S. CONG., OFFICE OF TECH. ASSESSMENT, *DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE* 3 (1994); Armand Leone, Jr., *As Health Care Enterprise Liability Expands . . . Is ADR the Rx for Malpractice?*, DISP. RESOL. J., Sept. 1994, at 7, 10; see also Laurence R. Tancredi, *Designing a No-Fault Alternative*, LAW & CONTEMP. PROBS., Spring 1986, at 277, 279 (citing *AMA Study Reports Sharp Increase in Malpractice Claims Against Physicians*, MED. LIAB. ADVIS. SERVICE, Jan. 1980, at 16); Joel Brinkley, *A.M.A. Study Finds Big Rise in Claims for Malpractice*, N.Y. TIMES, Jan. 17, 1985, at A1.

108 See S. Y. Tan, Comment, *The Medical Malpractice Crisis: Will No-Fault Cure the Disease?*, 9 U. HAW. L. REV. 241, 242 (1987).

109 See Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353, 387-88 (1996).

110 It may be argued that the nature of damages is a necessary but not sufficient factor to explain the difference in legal treatment between physicians and corporate officers and directors. If such an argument were advanced, the next step would be to determine what other factors, if any, are sufficient to justify this difference.

111 Of course, some of the work that attorneys do is not economic in nature. For instance, criminal defense work holds more at stake than just the protection of one's purse. Be that as it may, the bulk of work by most attorneys is purely economic.

112 See Gevurtz, *supra* note 75, at 313 (remarking that corporate directors are not unique among potential tort defendants in that their negligence is likely to lead to economic rather than physical injury—attorneys as a group are the example cited to make this point).



the different standards of care imposed on physicians and corporate officers and directors since that does not explain why the law discriminates between other potential defendants who cause only economic damages. Once again a justification relying on the difference in the nature of damages seems to prove too much.

### B. *Fear of Liability*

Fear of liability is the second—and related—explanation put forth by Arkes and Schipani to explain why a different standard of liability exists between physicians and corporate officers and directors. Although Arkes and Schipani advance this rationale, they are quick to point out that fear of liability “does not alone justify the differences in legal treatment in business and medicine.”<sup>113</sup> Fear of liability is more material in the medical context than in the business context and provides all the more reason why physicians should function under a regime similar to that of the business professional. In their analysis, Arkes and Schipani correctly state that a heightened standard of care unaccompanied by assurances of indemnification would exacerbate a director’s fear of liability and result in qualified individuals rejecting corporate positions. Naturally, as pointed out earlier, fewer people would be willing to serve as officers and directors if they were held personally liable for the substance of their decisions.<sup>114</sup> This is especially true when one considers that liability can result in millions of dollars in damages.<sup>115</sup> The result would be that the quality of people serving on corporate boards would decline along with the quality of their decisions. In other words, without the protection the business judgment rule affords directors, the quality of decisions should be expected to decline instead of improve.<sup>116</sup>

This very same reasoning would seem to apply to physicians in the medical context because fear of liability can also serve as a powerful impetus affecting a physician’s behavior, often for the worst. As already highlighted above, data purport to show that an increase in the rate of malpractice litigation has already caused a great number of physicians to engage in defensive medicine at onerous costs to the general public.<sup>117</sup> It is often asserted that fear of liability has also caused many physicians in certain specialties to decline to perform

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113 Arkes & Schipani, *supra* note 29, at 624.

114 See Hansen, *ALI Corporate Governance Project*, *supra* note 54, at 1239.

115 See, e.g., *Smith v. Van Gorkom*, 488 A.2d 858, 899 (Del. 1985) (Christie, J., dissenting).

116 See McEachin, *supra* note 65, at 384.

117 See *supra* notes 105–09 and accompanying text.

difficult or experimental procedures,<sup>118</sup> to leave high-risk geographic areas,<sup>119</sup> to abandon their particular area of medical practice in exchange for less litigious fields of medicine,<sup>120</sup> or to even retire early.<sup>121</sup> Moreover, fear of liability may also have an impact on the rate of students willing to matriculate in medical schools. The path to becoming a physician is by all accounts rigorous, time-consuming, and expensive.<sup>122</sup> If, on top of these hurdles, physicians must fear excessive and undue liability, it is only natural that many gifted and qualified individuals may seek different professions where it is not necessary to constantly look over one's shoulder. We note that Arkes and Schipani point out that the existence of licensing exams and other threshold requirements should in theory prevent unqualified individuals from replacing physicians who have chosen to abandon a particular area of their practice or retire completely.<sup>123</sup> Yet licensing exams and threshold requirements only assure basic competence—not experience or high quality medical services.

Some errors that occur in the course of medical treatment can arguably be attributed to lack of experience rather than simple incompetence or lack of qualifications. One can speculate that most of the physicians making career moves to distance themselves from liability are presumably seasoned veterans with both highly regarded reputations and significant assets in need of protection. As more and more older and experienced physicians change specialties, limit their practice, or retire, one could speculate that a greater number of younger and less experienced physicians are called on to fill the void left by these departures. As the inexperience of physicians performing high-risk procedures or specializing in high-risk areas of medicine increases, the quality of the decisions in these areas of medicine might well correspondingly decline. Therefore, as in the business context, it

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118 *E.g.*, SCHWARZ, *supra* note 105, at 21; JENNIFER O'SULLIVAN, MEDICAL MALPRACTICE 5 (CRS Report for Congress 1997) (citing an American College of Obstetrician and Gynecologists (ACOG) survey which reported that one-quarter of members reduced high-risk obstetrical care due to fear of tort liability).

119 *Medical Malpractice: Hearings on H.R. 5110 Before the Subcomm. on Health and the Env't of the House Comm. on Energy and Commerce*, 99th Cong. 80–81 (1986) (citing a 33% drop in number of practicing obstetricians in Florida alone).

120 O'SULLIVAN, *supra* note 118, at 5 (citing ACOG study indicating that 12.3% of members gave up obstetrics in 1992 because of fear of tort liability).

121 Moore & O'Connell, *supra* note 11, at 1270; Roger Rosenblatt, *Why Do Physicians Stop Practicing Obstetrics?: The Impact of Malpractice Claims*, 76 OBSTETRICS AND GYNECOLOGY 245, 245 (1990).

122 In fact, we argue below that the path to becoming a physician is the most laborious of the many graduate and professional programs available.

123 Arkes & Schipani, *supra* note 29, at 624.

can be argued that without physicians receiving sufficient protection by measures similar to the business judgment rule—thereby lessening their fear of liability—the quality of decisions in high-risk medical ventures should be expected to fall, not rise.

Moreover, when one compares the corporate and medical professions, it quickly becomes evident that physicians are indeed short-changed when it comes to protection from liability. Officers and directors are provided with four times the protection that exists for physicians. The first line of defense is the less stringent due care standard that directors are held to—with rare exceptions—in spite of the traditionally tort-derived language which defines duty in terms of the care an ordinarily prudent person in a like position would exercise under like circumstances.<sup>124</sup> The second line of defense shielding officers and directors from liability is the business judgment rule. As already elaborated above,<sup>125</sup> the business judgment rule is the nucleus of American corporate jurisprudence and has made the presence of cases finding officers and directors liable for due care violations almost nonexistent.<sup>126</sup> The third line of defense shielding officers and directors from liability is the exculpatory legislation that nearly all states have passed to further protect corporate officers and directors above and beyond the protection already afforded by the business judgment rule.<sup>127</sup> The fourth line of defense is the availability of indemnification that corporations may grant their officers and directors. Justifications for the business judgment rule and its legislative supplements purport to serve judicial economy; to foster an environment conducive to corporate growth; to protect the corporate entity from excessive and costly litigation; to afford officers and directors relative peace of mind thereby reducing work-related distractions and inefficiency; and to protect the interests of shareholders who would ultimately bear the burden of paying for the defense and indemnification of officers and directors in addition to any monetary remedies awarded to plaintiffs. Hence, the business judgment rule can be seen as existing less for the benefit of officers and directors and more for the benefit of corporate America and capitalism in general.

Note the contrasts: first, physicians do not normally function under the auspices of a “medical judgment rule.” Although some jurisdictions, most notably New York,<sup>128</sup> do afford their physicians some

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124 See *supra* note 54 and accompanying text.

125 See *supra* notes 55–65 and accompanying text.

126 See *supra* notes 66–68 and accompanying text.

127 See *supra* notes 69–71 and accompanying text.

128 See, e.g., *Bell v. N.Y. Health & Hosps. Corp.*, 90 A.D.2d 270 (N.Y. App. Div. 1982).

protection under the "professional judgment rule" the scope of such protection has been limited, with the doctrine most often being invoked by psychiatrists.<sup>129</sup> Second, exculpation is not generally available for physicians. Third, despite indemnification being common amongst both physicians and corporate officers and directors, unlike the latter, physicians must personally gain indemnity by purchasing their own malpractice insurance policies.<sup>130</sup> In the face of the recurrent malpractice crises, premiums for insurance policies have often skyrocketed.<sup>131</sup> The result has been that physicians have often been forced to allocate larger portions of their salaries to cover this expenditure.<sup>132</sup> Even physicians with impeccable records still suffer from soaring premiums since malpractice insurance is largely priced by specialty and location, not individual merit.<sup>133</sup>

Even worse, in some specialties, physicians complain about how difficult it is to locate insurers willing to issue any policies.<sup>134</sup> Naturally, many physicians feel both angry and bitter that courts and legislatures have allowed matters to get so out of control.<sup>135</sup> Consequently, physicians, more than corporate officers and directors, might well evoke fear of counterproductive liability as grounds to support a doctrine similar to the business judgment rule in the medical context.

### C. *Lack of Accepted Methodologies*

Lack of accepted methodologies is the third explanation provided by Arkes and Schipani to explain why a different standard of liability exists for physicians and corporate officers and directors. According to Arkes and Schipani, "There is no commonly accepted methodology as to what a business person should do when faced with

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129 See Arkes & Schipani, *supra* note 29, at 606.

130 One can argue that corporate officers and directors ultimately pay to receive exculpation by being offered smaller salaries for their services.

131 See 1 AM. LAW INST., REPORTERS' STUDY: ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 285-89 (1991).

132 Although it can be argued that physicians will pass on the expenses of higher premiums to patients and their health insurance companies, it seems unlikely that such a response—especially in today's age of cost-containment policies, medical utilization review, and purchasing agreements—will necessarily enable physicians to capture the increased costs of delivering medicine.

133 See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 399 (1994). The standardization of premium rates for liability insurance is justified on the grounds that "from the insurer's as well as from the physician's point of view, having been sued is a sufficiently rare and random event that it gives very little evidence about the general quality of a physician's work." See Weiler, *supra* note 14, at 1191 n.60.

134 See Abraham & Weiler, *supra* note 133, at 401-02.

135 See AM. LAW INST., *supra* note 131, at 287-89.

every business situation.”<sup>136</sup> In contrast, they contend that there are “commonly accepted methodologies for treating many diseases” and that the “medical standard of care . . . presupposes that there is a set of actions that a competent practitioner should take.”<sup>137</sup>

Using an example of a surgeon, they assert that “there may be a general common way of assessing and describing the accepted notion of what a surgeon is supposed to do and how he or she is supposed to act in a particular instance.”<sup>138</sup> Yet, does ex post judicial review of business decisions pose any greater difficulty than that found in the medical context?

First, contrary to Arkes and Schipani’s conclusion, commonly accepted methodologies would seem to exist concerning what officers and directors should do in particular situations. The very existence of a formal business education<sup>139</sup> would seem to challenge the notion that business decisions are entirely unguided undertakings lacking accepted standards of norms.<sup>140</sup> Furthermore, the argument that there is an absence of accepted practices and protocols for officers and di-

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136 Arkes & Schipani, *supra* note 29, at 624.

137 *Id.* at 625.

138 *Id.*

139 Critics may argue that because the corporate field lacks threshold requirements, some officers and directors may not have the knowledge or training of those who have received a formal business education. But these individuals, under the law corporate governance standards, are still held to the same objective standard of due care. See *Francis v. United Jersey Bank*, 432 A.2d 814, 822 (N.J. 1981).

140 See Gevurtz, *supra* note 75, at 308 & n.92 (citing Gordon Christy, *Corporate Mismanagement as Malpractice: A Critical Reanalysis of Corporate Managers’ Duties of Care and Loyalty*, 21 Hous. L. Rev. 105 (1984)).

For example, one of the common areas involving board approval, and a frequent source of legal challenges to the board’s decision, is the buying and selling of businesses or major business assets. *E.g.*, Stuart R. Cohn, *Demise of the Directors’ Duty of Care: Judicial Avoidance of Standards and Sanctions Through the Business Judgment Rule*, 62 TEX. L. REV. 591, 596–97 (1983). Here one of the primary issues is price. FRANKLIN A. GEVURTZ, *BUSINESS PLANNING* 796–804 (1991). While business valuation is certainly more of an art than a science, to say it is an art without any established guidelines or methodologies is to ignore huge quantities of available literature. *E.g.*, HAROLD BIERMAN, JR. ET AL., *QUANTITATIVE ANALYSIS FOR BUSINESS DECISIONS* (8th ed. 1991); ARTHUR S. DEWING, *FINANCIAL POLICY OF CORPORATIONS* (5th ed. 1953); EUGENE F. FAMA & MERTON H. MILLER, *THE THEORY OF FINANCE* (1972); DENNIS E. LOGUE, *HANDBOOK OF MODERN FINANCE* (2d ed. 1990); JAMES C. VAN HORNE, *FINANCIAL MANAGEMENT AND POLICY* (5th ed. 1980); J. FRED WESTON & EUGENE F. BRIGHAM, *MANAGERIAL FINANCE* (4th ed. 1972).

*Id.* at 308 n.92; *cf.* Davis, *supra* note 76, at 582–84 (discussing the possibility of standards for business professionals, such as directors, in the context of the business judgment rule).

rectors becomes even more suspect for actions undertaken at the level of the board of directors.<sup>141</sup> Directors serving on a board act together as one board and their decisions represent a consensus that was reached by all or most of its members. Consequently, a board's decision is the product of group deliberations—not a single individual's best judgment, as may be the case with physicians.<sup>142</sup> Therefore, if anything, one would expect to find that group decisions are grounded in reasoning that can be examined by after-the-fact reviewers. Often the same cannot be said for physicians.

Assuming, however, that business decisions are more nebulous in nature and do pose greater difficulties for ex post review when compared to medical decisions, this would arguably provide all the more reason why officers and directors should not need the protection of the business judgment rule.<sup>143</sup> According to Professor Gevurtz, the more discretionary a decision and/or the less a decision is held in unanimity, the more difficult it becomes for claimants to establish that a particular decision was unreasonable—much less that a different decision would have necessarily produced a more favorable outcome.<sup>144</sup> Therefore, a purported lack of methodologies in the business context would not seem to disserve corporate officers and directors in litigation; instead, it works to the detriment of those who carry the burden of proof—namely claimants.<sup>145</sup>

With regard to physicians, the art of medicine has not—yet, anyway—been reduced to rigid guidelines and protocols detailing what is and is not acceptable for a given patient during the course of treatment.<sup>146</sup> The Institute of Medicine<sup>147</sup> defines practice guide-

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141 See Gevurtz, *supra* note 75, at 308.

142 See *id.* at 308 & n.93 (citing *see, e.g.,* William H. Rodgers, Jr., *Negligence Reconsidered: The Role of Rationality in Tort Theory*, 54 S. CAL. L. REV. 1, 6–7 (1980) (“This is not to say that group deliberations yield better results; merely that there is more likely to be an articulated rationale or rationales for the group’s action.”)). But for the distinction between “deciding” and “doing,” see *infra* notes 220–22 and accompanying text.

143 As the reader will sense, we do not in any way advocate the elimination of the business judgment rule; instead, we argue that many of the rationales given to justify its exclusive existence seem misplaced.

144 See Gevurtz, *supra* note 75, at 309–10. For an analysis examining why trial lawyers are not more often found negligent for their trial work due to the largely judgmental nature of their of decisions see *id.*

145 See *id.* at 310.

146 For an insightful article echoing many of the points made herein concerning practice guidelines, see Karen A. Butler, Comment, *Health Care Quality Revolution: Legal Landmines for Hospitals and the Rise of the Critical Pathway*, 58 ALB. L. REV. 843, 856 (1995).

147 The Institute of Medicine is a private, nonprofit society of the National Academy of Sciences. See IOM, *supra* note 11, at iii.

lines<sup>148</sup> as "systematically developed statements [of recommendations for patient care management] to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."<sup>149</sup> Practice guidelines have been in existence since the early 1930s.<sup>150</sup> In response to private institutions implementing guidelines, and some courts utilizing these guidelines, Congress<sup>151</sup> and several states have passed legislation concerning the use and development of medical malpractice guidelines.<sup>152</sup> In general, guidelines are recommendations that serve the purpose of "describing effectiveness and appropriateness of alternate approaches in detecting, diagnosing, and managing specific symptoms or disease states."<sup>153</sup> The problem is that the many mysteries of disease and illness and the human body's response to them, are still in many regards unclear. Even when clear, however, the problems of developing a consensus as to specified therapies (when several alternatives are available) and the detailed terminology necessary to describe the characteristics of both disease and courses of treatment still persist.

Also, because individuals may respond differently to any one common form of treatment, which may be the result of allergic reac-

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148 Other terms such as "standards," "parameters," and "practice options" are also sometimes included in a discussion of medical guidelines. Each bears different definitive levels of recommendation and meaning. A report to Congress on "Practice Guidelines" by the United States General Accounting Office defined a standard as "practice policies [in] which the consequence of an intervention on health and economics is sufficiently well-known and there is virtual unanimity (by the promulgators) about the desirability or undesirability of the intervention and about the proper use, or non-use of that intervention." Lori Rinella, Comment, *The Use of Medical Practice Guidelines in Medical Malpractice Litigation—Should Practice Guidelines Define the Standard of Care?*, 64 UMKC L. REV. 337, 337 n.5 (1995) (citing U.S. GEN. ACCOUNTING OFFICE, PRACTICE GUIDELINES: THE EXPERIENCE OF MEDICAL SPECIALTY SOCIETIES, REPORT TO CONGRESSIONAL REQUESTERS 12 (1991)). Practice guidelines "are recommendations that are understood well-enough to permit meaningful decisions about proper uses of a health care intervention, and an appreciable, but nonunanimous, majority of physicians and informed patients share the preferences regarding the intervention." *Id.* Practice options refer to when an "intervention is a reasonable choice of course but the outcomes are not known, or a significant portion of physicians or patients feel the intervention is not worth the benefit, not known or are evenly divided." *Id.*

149 *Id.* at 337 (citing Kathleen N. Lohr, *Guidelines for Clinical Practice: What They Are and Why They Count*, 23 J.L. MED. & ETHICS 49, 49 (1995) (citation omitted)).

150 See Gilbert B. Bluhm, *President's Page: Practice Parameters—Physician Input Is Key*, 93 MICH. MED. 68, 68 (1994).

151 See Omnibus Budget Reconciliation Act of 1989 § 1901, 42 U.S.C. § 299 (Supp. V 1999).

152 See Rinella, *supra* note 148, at 339.

153 *Id.* at 338 (citing Adam Wolff, *Practice Parameters in Health Reform: New State Approaches Precede Clinton Plan*, 21 J.L. MED. & ETHICS 394 (1995)).

tions, medication, their body's chemistry, other preexisting ailments, etc., no guideline can possibly capture the appropriate treatment for all persons—especially when dealing with highly complex areas of medicine. Oftentimes, a diagnosis may leave a physician with several acceptable methods of treatment, each of which may bear comparable, but different, risks that may materialize for the patient at hand. In order for guidelines to account for such situations, many would have to be drafted in general terms while others would have to be drafted in confining detail, both being therefore suspect. Moreover, at times several different conflicting guidelines may be written for the treatment of one particular condition, which brings into question the reliability of some guidelines, both generally or for any given case.

In other words, the practice of medicine is case specific. It requires physicians to rely on science, experience, intuition, and the history of a particular patient in order to determine the appropriate course of treatment. It is difficult for any guideline to capture all these factors, and, should one be developed, its utility in practice might be questionable. Additionally, a consequence of such guidelines might be the underdevelopment of clinical reasoning skills, especially for young physicians.<sup>154</sup> Simply put, it is often asserted that the art of medicine cannot be relegated to the status of a cookbook.

Consequently, though general guidelines may prove useful to a physician, should deviation from such guidelines justify liability if an unfavorable result occurs? This question seems especially appropriate since guidelines only reflect those practices held in acceptance by the majority whereas other practices supported by a respected minority go unendorsed as alternatives. Moreover, because medicine is an evolving discipline it would be difficult for published standards of protocols to reflect cutting-edge approaches to healing. The development and dissemination of guidelines for use by practitioners is estimated to take approximately two years.<sup>155</sup> In certain medical fields this production rate results in many guidelines becoming outdated prior to their general availability. This was the situation in Sweden, where as a result of guidelines being unable to reflect recent medical advancements, a fifteen-year-old clinical guideline program was abandoned.<sup>156</sup> Furthermore, physicians' efforts to avoid liability may

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154 See Butler, *supra* note 146, at 854–55 (citing Steven H. Woolf, *Practice Guidelines: A New Reality in Medicine* (pt. 3), 153 ARCHIVES INTERNAL MED. 2646, 2650 (1993)).

155 See *id.*

156 *Id.* at 855. As to the widespread failure to follow practice guidelines in the U.S. see Michael D. Cabana et al., *Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement*, 282 JAMA 1458, 1458 (1999).



also result in physicians strictly adhering to certain guidelines, despite the existence of more suitable treatments.<sup>157</sup> It should also be noted that certain percentages of patients complain of symptoms that are uncharacteristic of any familiar categories of diagnosis and treatment.<sup>158</sup> According to Gevurtz, "While different doctors place the proportion of such patients at different levels, this level may be as high as eighty-five percent."<sup>159</sup> Assuming this supposition true, it would only further bolster a belief that the availability of methodologies does not appropriately serve as a basis to explain why a difference in legal liability exists for physicians and corporate officers and directors.

On this subject of accepted methodologies, Dean Kenneth Davis, of the University of Wisconsin Law School, states that the difference between liability for professionals such as physicians and immunity for corporate officers and directors stems

not [from the fact] that we assume that [judges and juries] have the personal expertise to make an informed assessment [of the professional actions of, say, a neurosurgeon] on their own. We instead rely on expert testimony. Underlying that reliance is the assumption that there exists a generally accepted body of principles and procedures dictating how a reasonable neurosurgeon should respond in a variety of situations. Consequently, we are comfortable permitting the fact finder to draw inferences about what the defendant neurosurgeon should have done from the expert's opinion on what he or she would have done if confronted with the same situation.<sup>160</sup>

But foregoing material in this Article<sup>161</sup> undermines confidence in the validity of expert opinion as a comparatively ready means of disposing of medical malpractice cases, in contrast, for example, to cases against corporate officers and directors. Note furthermore, that in the typical medical malpractice case there is not just one expert opinion to guide the lay trier of fact, but two (or more). And, given

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157 See Ed Hirshfeld, *Use of Practice Parameters as Standards of Care and in Health Care Reform: A View from the American Medical Association*, 19 JOINT COMM'N J. ON QUALITY IMPROVEMENT 322, 323 (1993).

158 See Gevurtz, *supra* note 75, at 309.

159 *Id.* at 309 (citing DONALD A. SCHON, *THE REFLECTIVE PRACTITIONER: HOW PROFESSIONALS THINK IN ACTION* 16 (1983)); see also Bovbjerg, *supra* note 103, at 329 (measuring the quality of medical care is especially difficult given that medicine is as much an art as a science and given the complexities of the human organism); David Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179, 1182 (stating that standards of medical practice are ambiguous).

160 Davis, *supra* note 76, at 581-82.

161 See *supra* notes 10-14, 29-49 and accompanying text.

the adversarial nature of litigation, those expert opinions will entail dramatically *opposing* opinions on what the defendant physician did, should have done, or should not have done. Thus, medical malpractice cases inevitably turn lay triers of fact into "appellate boards of physicians," an outcome just as fearful as turning the laity into "appellate boards of directors."<sup>162</sup>

In measure though, Davis's discussion can be seen as echoing, in part at least, an extraordinarily perceptive and convincing thesis advanced by the senior author's colleague at the University of Virginia School of Law, Professor Kenneth Abraham. Abraham argues that typical personal injury litigation, arising, say, from auto accidents, is based on "unbounded" standards, thereby becoming excessively fact-oriented.<sup>163</sup> According to this view, such litigation thus fails to grow into predictable rules upon which the outcome of litigation can be forecast.<sup>164</sup> One is reminded of the remarks of Karl Llewellyn in another context. Specifically, that for the courts,

the cases run into the [hundreds of] thousands and with no reck-onability anywhere in sight. Unpredictably, [courts] . . . proceed to spit the [accident] victim for the barbecue [or] [w]ith equal unpre-dictability they [impose liability] . . . . The difficulty with these tech-niques is . . . they fail to accumulate either experience or authority in the needed direction: that of marking out for any given type of [incident] . . . what . . . a court will insist upon as essential to . . . [liability] . . . .<sup>165</sup>

On the other hand, Abraham characterizes litigation in areas such as medical malpractice as being "bounded"—principally by accepted practices delineated by expert testimony.<sup>166</sup> But in this respect, Abraham seems overly modest in applying his very telling theory. Actually, the hugely indeterminate nature of medical malpractice litigation belies the tight distinction between bounded and unbounded categories of tort liability. True, medical malpractice cases might be characterized as "bounded," if you can call it that, by the diametrically contrasting views of experts at opposite ends of a wide spectrum. But how helpful in supplying certitude for a given case or future cases is such a boundary?

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162 See *supra* note 73 and accompanying text.

163 See Kenneth Abraham, *The Trouble with Negligence*, 54 VAND. L. REV. 1187, 1193–94 (2001).

164 See *id.*

165 KARL N. LLEWELLYN, *THE COMMON LAW TRADITION: DECIDING APPEALS* 364–65 (1960) (discussing vagueness in the enforceability of unconscionable contracts).

166 See Abraham, *supra* note 163, at 1199.

It seems especially significant that Abraham assigns product liability cases to the "unbounded" category. He writes:

We have too many different ways of behaving, and too many different conceptions of how people ought to behave, to expect widespread agreement about which individual behaviors count as reasonable and which as negligent [according to the standards of the community]. In factually more complex but still unbounded cases—for example, products liability cases involving design defects or the failure to warn—it is even less likely that there is any kind of single community [standard] . . . about how safe a particular product design should be, or how much detail should be included in a warning about the side effects of a prescription drug.<sup>167</sup>

And yet product liability, like medical malpractice, cases involve professional standards—in this case engineering instead of medical. That explains why product liability, like medical malpractice cases, normally require expert testimony. If they nevertheless end up for Professor Abraham as unbounded, that seems to blur the availability of professional standards enunciated by expert witnesses as controlling. In practice, medical malpractice cases turn out to be not so much bounded but about as vague and standardless as many of those areas Abraham characterizes—and so effectively condemns—as unbounded.

#### D. *The Aura of Science*

The aura of science is the fourth explanation put forth by Arkes and Schipani to explain why a different standard of liability exists between physicians and corporate officers and directors. Even though this explanation is presented as a possibility that needs to be explored, it is not one that is taken seriously even by Arkes and Schipani. The argument goes that "[b]ecause illness has chemical, biological, or physical causes, and because chemistry, biology, and physics are sciences, a layperson may assume that a physician trained in science should be able to deduce the cause of every possible symptom."<sup>168</sup> Consequently, laypersons may hold physicians to know the outcome of all possible physical or chemical treatments. All bad outcomes, therefore, may be deemed the offspring of either negligent diagnosis or treatment, or both.

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167 Abraham, *supra* note 163, at 1195.

168 Arkes & Schipani, *supra* note 29, at 626.

But, as Arkes and Schipani conclude, physicians are not by any means omnipotent nor are they guarantors of good outcomes.<sup>169</sup> If, however, it should be shown that the above skewed perception of reality is an accurate depiction of a typical layperson's mentality concerning the diagnosis and treatment of disease, then this would provide all the more reason to question the second-guessing of physicians by laypersons in medical malpractice cases. In sum, the use of "the aura of science" as a means to resolve the difference in legal treatment between physicians and corporate officers and directors is questionable at best, as Arkes and Schipani quickly concede.

### *E. Threshold Requirements*

Threshold requirements are the fifth explanation suggested by Arkes and Schipani to help explain why a different standard of liability exists for physicians and corporate officers and directors. Arkes and Schipani observe that "unlike the high threshold requirements to enter the health professions, there are virtually no threshold requirements of significance for serving on a corporate board. There is no education required, no licensing requirement, no state board to pass."<sup>170</sup> They write, "All that is needed to serve on a corporate board is a majority vote of the shareholders voting at the shareholders' annual meeting."<sup>171</sup> Not so for physicians. As indicated earlier, physicians have extensive, rigorous licensing requirements that they must meet before they are permitted to practice medicine. Those unable to satisfy these requirements are forbidden from practicing medicine while those who meet all such requirements are given a monopoly allowing them alone to practice.<sup>172</sup> Arkes and Schipani then conclude that "[p]ersons who are granted this monopoly may be obligated to meet a much higher standard than business persons. The latter have no threshold requirements, and thus society may have lower expectations for them."<sup>173</sup>

But if anything, in the case of corporate officers and directors the lack of required formal training, the absence of licensing exams, and the non-existence of state board exams provide courts with legitimate reasons why triers of fact *should* be able to second guess the decisions of corporate officers and directors. Since a person of no or highly

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169 *Id.*; see also *Wilkinson v. Vesey*, 295 A.2d 676, 682 (R.I. 1972) (holding that physicians do not guarantee either a correct diagnosis or successful treatment).

170 Arkes & Schipani, *supra* note 29, at 627.

171 *Id.*

172 *Id.*

173 *Id.*

questionable training, prudence, and business perspicacity can serve as a corporate officer or director, it could persuasively be argued that the interest of shareholders lies in allowing courts to supervise business decisions to ensure that officers and directors are living up to an appropriate standard. Though of course other problems would arise if courts were permitted to serve as appellate boards of directors; on a strictly threshold requirement argument, the absence of criteria to separate the competent from the incompetent would justify courts' reevaluating the decisions of officers and directors more than those of physicians.

Thus, the comprehensive education and training that physicians receive provide all the more reason why courts should not routinely be in the business of second-guessing the medical decisions of physicians. Absent bad faith,<sup>174</sup> a presumption might well be made that in making medical decisions physicians acted on an informed basis and in the honest belief that the action taken was in the best interest of the patient. Medicine is by far the most demanding graduate or professional program in the country. Unique to other graduate or professional schools, all AMA certified medical schools have traditionally required applicants to satisfy a comprehensive list of undergraduate courses prior to enrolling into medical school.<sup>175</sup> Applicants have traditionally been required to take one year of chemistry and lab, one year of organic chemistry and lab, one year of biology and lab, one year of physics and lab, one year of mathematics (required by most medical schools), and some programs recommend a course in biochemistry.<sup>176</sup> Because competition into medical schools is extremely fierce, and some might even say cutthroat,<sup>177</sup> students attending American medical schools are extremely bright and competent with a

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174 Intentional misconduct, egregious, irrational, wanton, criminal, or fraudulent conduct could all be treated as negating good faith. That is, they can be seen as the equivalent of bad faith. See *infra* note 245 and accompanying text.

175 For instance there are no pre-law and generally no pre-business requirements that must be satisfied before entering American law or business schools.

176 Duke University School of Medicine is one such school that encourages its medical students to complete a biochemistry course before the first day of medical school classes. BULLETIN OF DUKE UNIVERSITY 2000-2001, DOCTOR OF MEDICINE PROGRAM 35 (2001), [http://registrar.duke.edu/bulletins/Medicine/2000/doc\\_med.PDF](http://registrar.duke.edu/bulletins/Medicine/2000/doc_med.PDF).

177 The year 2000 medical school acceptance rate compiled by *U.S. News & World Report* speaks to the briskness of competition for medical school seats. Of the top fifty-one research medical schools in the report, forty schools had a single digit acceptance rate. Of these top fifty-one schools, Boston University had the most stringent acceptance rate (2.1%) and the University of Massachusetts—Worcester had the least stringent (22.2%). *Best Graduate Schools*, U.S. NEWS & WORLD REP., Apr. 9, 2001, at 88, available at <http://www.usnews.com/usnews/edu/beyond/bcrank.htm>.

certain propensity toward the sciences. They are commonly described as the "crème de la crème." Once in medical school, no other graduate or professional school is physically, emotionally, and intellectually as demanding, let alone longer in duration.<sup>178</sup> After completing an intensive medical school curriculum that requires passing Part 1 and Part 2 of the United States Medical Licensing Exam (USMLE), generally all graduates are then required to intern for one year's time at the conclusion of which they must pass Part 3 of the USMLE. Thereafter, medical school graduates must satisfy a residency program that spans some years in length, the precise number depending on specialty and sub-specialty. At the conclusion of each residency program, physicians then face their specialty-specific state board exam.<sup>179</sup>

Thus, the skills and knowledge that physicians possess stem from over a decade, and in some sub-specialties two decades, of training. It seems questionable that the tort system would expect ordinary laypersons to routinely grasp in a short period of a trial what it has taken physicians (with scientifically-oriented minds) years to learn, especially when they must choose between the diametrically opposing views of competing expert witnesses. The fact that expert witnesses must talk down to jurors and speak in "plain English" even further calls into question juries being called on to resolve typical medical malpractice disputes. Moreover, one must keep in mind that the triers of fact are not being asked to resolve disputes that are black and white; such disputes are more likely resolved by settlement or pretrial motions. Instead, triers of fact are often being asked to decide the taxing gray borderline cases. Therefore, contrary to Arkes and Schipani, threshold requirements only further undermine the proposition that courts are equipped to serve the role of "appellate boards of physicians."<sup>180</sup>

#### *F. Reliance on Market Efficiencies*

Reliance on market efficiencies is the sixth explanation proposed by Arkes and Schipani to help answer why there remains a difference

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178 Medical school and dental school are four years in duration, law school is three years, a Masters of Business Administration (MBA) program is two years, a masters degree typically requires two to three years of study, and a Ph.D. program usually takes at least three to four years to complete. Certified public accountants (CPAs) are not required to have a graduate degree to sit for the CPA exam; 120 credit hours was formerly required but this has recently been changed to 150 credit hours. Most engineers work with a bachelors of science degree that takes four to five years to earn.

179 No other profession, to our knowledge, requires its members to complete a residency program.

180 See *supra* note 73 and accompanying text.

in legal liability for physicians and corporate officers and directors. According to this argument, various market mechanisms serve as checks on officers' and directors' behavior, and help assure that the interests of management and shareholders are in accord.<sup>181</sup> Arkes and Schipani list several market mechanisms that aid in curbing managerial abuse and misconduct; these include "the managerial labor market, the product market, the capital market and the market for corporate control."<sup>182</sup>

The managerial labor market serves as an effective check on management by rewarding satisfactory job service with continued employment, compensation, and the potential for advancement<sup>183</sup> while penalizing suboptimal performance with termination, demotion, and/or reduced pay. The product market, which requires firms to operate efficiently in order to remain competitive and profitable, also serves as a strong market check on corporate officers and directors.<sup>184</sup> Assuming a healthy market, poor decisions that lead to the output of overly expensive or inadequate products would result in rival companies competing to produce better products more efficiently (i.e., lower costs), ultimately passing on the savings to consumers. The firm governed by poor management can obviously be expected to suffer from a loss of sales and a decrease in profit. Prolonged losses may eventually lead to bankruptcy and the loss of jobs for employees, as well as corporate officers and directors. Consequently, the product market helps assure that management and shareholders continue to function in a symbiotic relationship.

Moreover, the capital market too serves as a check by punishing inefficiently run corporations by making their accessibility to capital more difficult and costly.<sup>185</sup> Ultimately, however, it is often argued the market for corporate control serves as the greatest check on corporate management.<sup>186</sup> Corporations that are poorly managed may also be undervalued, thereby making them attractive and vulnerable targets for hostile takeovers. Takeover companies that do succeed in acquiring a target firm would then be expected to implement profit-maximizing policies to capture the intrinsic value of their newly ac-

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181 See, e.g., Daniel R. Fischel & Michael Bradley, *The Role of Liability Rules and the Derivative Suit in Corporate Law: A Theoretical and Empirical Analysis*, 71 CORNELL L. REV. 261, 275-76 (1986); David M. Phillips, *Principles of Corporate Governance: A Critique of Part IV*, 52 GEO. WASH. L. REV. 653, 672-82 (1984).

182 Arkes & Schipani, *supra* note 29, at 628.

183 See *id.*

184 See *id.*

185 See *id.*

186 *Id.*

quired corporation. This in turn would commonly include the termination of top management from the target company. Therefore, the market for corporate control forces officers and directors to either lead efficiently and effectively or risk losing their posts.

Arkes and Schipani contend, however, that "many of the disincentives to corporate managers for poor judgement . . . simply do not apply in medicine."<sup>187</sup> But in fact some market and related mechanisms do exist in medicine to deter substandard behavior in the delivery of health care. First, the National Practitioner Data Bank (NPDB) purports to serve to constrain and penalize physicians who exercise poor judgement in treating patients. Authorized by congressional action in 1986 as a component of the Health Care Quality Improvement Act (HCQIA),<sup>188</sup> the NPDB is a federal repository to compile and disseminate information regarding not only medical malpractice payments, but also adverse disciplinary actions involving hospital privileges or society memberships registered against health care professionals.

HCQIA requires any entity (including insurers), making any payment on any written medical malpractice action or claim, to report such payments to both the NPDB and the State Licensing Board, within thirty days of actual payment, subject to a \$10,000 fine for each incident of non-reporting.<sup>189</sup> State Boards of Medical Examiners and health care entities, such as hospitals, are also required to report any professional review action adversely affecting the clinical privileges or licensure of a physician or dentist for longer than thirty days.<sup>190</sup> HCQIA further requires the NPDB be notified when a physician's clinical privileges have been relinquished under circumstances when the physician's professional conduct or competence is under investigation, or when a physician has relinquished his/her clinical privileges in return for an investigation not to be conducted.<sup>191</sup>

The Act's federal mandatory reporting requirements exceed those existing under relevant state law. Under HCQIA, a physician cannot be hired on the medical staff of a health care entity or be granted clinical privileges by a health care entity until such entity has received requisite information from the NPDB.<sup>192</sup> Once a physician has joined the staff of a health care entity or been granted clinical

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187 *Id.* at 629.

188 Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11101-11152 (1994)).

189 42 U.S.C. § 11131(a), (c) (1994); *see also* IOM, *supra* note 11, at 121.

190 *See id.* § 11133(a)(1)(A).

191 *See id.* § 11133(a)(1)(B)(i)-(ii).

192 *See id.* § 11135(a)(1).



privileges, such entity is then required under the Act to request information at least once every two years on its physicians.<sup>193</sup> Health care entities are also given the freedom to request information from the NPDB at all other times.<sup>194</sup> A hospital that fails to request information respecting a physician as required by 42 U.S.C. § 11135(a) is presumed to have knowledge of all information contained in the data bank,<sup>195</sup> thus exposing a hospital to liability in a malpractice action for employing an incompetent physician.<sup>196</sup>

The existence of the NPDB and its mandatory use by health care entities has created much concern and anxiety on the part of physicians. As can be imagined, most physicians fear that adverse actions found in their NPDB files will harm their professional careers, especially since "health care entities attempt to distance themselves from physicians who might expose the institution or organization to an increased risk of vicarious and/or corporate liability."<sup>197</sup> The corporate liability theory stems from the case of *Darling v. Charleston Community Memorial Hospital*.<sup>198</sup> Corporate liability is a doctrine under which a hospital is held liable if it fails to uphold the appropriate standard of care owed to patients, namely the duty to secure a patient's safety and well-being while at the hospital.<sup>199</sup> That duty is nondelegable and is owed directly to the patient.<sup>200</sup>

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193 See *id.* § 11131(a)(2).

194 Note, however, whenever possible, hospitals may often settle claims on their own without including any physician's name in the settlement in order to avoid the reporting requirement as to physicians.

195 See 42 U.S.C. § 11135(b).

196 For more information on the NPDB and its operation, see generally Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J.L. & MED. 455 (1990); Ila S. Rothschild, *Operation of the National Practitioner Data Bank*, 25 J. HEALTH & HOSP. L. 225 (1992).

197 Marshall B. Kapp, *Medical Error Versus Malpractice*, 1 DEPAUL J. HEALTH CARE L. 751, 770 (1997) (citing BARRY R. FURROW ET AL., HEALTH LAW 265-88, chs. 7-8 (1995)); see also Robert L. Wilson, Jr., *Corporate Negligence of Hospital*, in 2 MEDICAL & HOSP. NEGLIGENCE §§ 20:01-12 (Miles J. Zaremski & Louis S. Goldstein eds., 1988); Robert L. Wilson, Jr., *Respondent Superior*, in 2 MEDICAL & HOSP. NEGLIGENCE, *supra*, §§ 19:0-10; Jennifer Steinhauer, *Legislators Approve Web List Disclosing Misssteps by Doctors*, N.Y. TIMES, June 24, 2000, at A1. But as to the inadequacy of the NPDB and other reporting systems, see, for example, Sandra G. Boodman, *Still Trying To Open Database on Doctors*, WASH. POST, Mar. 7, 2000, at 13 (Health Magazine); *Must Mistakes Happen?*, WASH. POST, Dec. 2, 1999, at A38; Jennifer Steinhauer, *Hospitals in City Faulted by State for Failing To Report Many Errors*, N.Y. TIMES, Feb. 13, 2001, at B1; James B. Stewart, *Doctors Who Kill*, WASH. POST, Sept. 10, 2000, at B7.

198 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).

199 See *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991).

200 *Id.*

The theory underwent further development under *Thompson v. Nason Hospital*,<sup>201</sup> where the court held that a hospital's duties extend into four general areas: (1) the maintenance of safe and adequate facilities and equipment; (2) *the selection and retention of only competent physicians*; (3) the overseeing of all persons permitted to practice medicine within its walls; and (4) the formulation, adoption, and enforcement of adequate rules.<sup>202</sup> With the existence of respondeat superior, and other agency and corporate liability rules,<sup>203</sup> the incentives for hospitals to distance themselves from high-risk medical providers are arguably greater than ever.

Accordingly, physicians perceived as being "second-rate" medical providers should encounter similar difficulties through market and regulatory forces, as those existing for "second-rate" corporate officers and directors through the managerial labor market and the market for corporate control. Just as one would expect that unsatisfactory job performance by officers and directors would lead to poor performers being terminated, demoted, losing corporate control, or having difficulties finding new employment, likewise, one would expect that physicians with blemished dossiers would also suffer unpleasant fates such as discharge from medical staff positions, loss of clinical privileges,<sup>204</sup> loss of patients, or even inability to find new employment.<sup>205</sup> Further-

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201 *Id.* at 703.

202 *See id.* at 707.

203 The doctrine of corporate liability has been recognized by at least seventeen jurisdictions. *See* *Bryant v. McCord*, No. 01A01-9801-CV-00046, 1999 Tenn. App. LEXIS 26, at \*27 (Ct. App. Jan. 12, 1999) (citing the following jurisdictions as having recognized the corporate liability doctrine, although declining to adopt the doctrine in Tennessee: *Tucson Med. Ctr., Inc. v. Misevch*, 545 P.2d 958, 960 (Ariz. 1976); *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 157 (Ct. App. 1982); *Kitto v. Gilbert*, 570 P.2d 544, 550 (Colo. Ct. App. 1977); *Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989); *Mitchell County Hosp. Auth. v. Joiner*, 189 S.E.2d 412, 414 (Ga. 1972); *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 258 (Ill. 1965); *Ferguson v. Gonyaw*, 236 N.W.2d 543, 550 (Mich. Ct. App. 1975); *Gridley v. Johnson*, 476 S.W.2d 475, 484-85 (Mo. 1972); *Foley v. Bishop Clarkson Mem'l Hosp.*, 173 N.W.2d 881, 884 (Neb. 1970); *Corleto v. Shore Mem'l Hosp.*, 350 A.2d 534, 537-38 (N.J. Super. Ct. Law. Div. 1975); *Raschel v. Rish*, 488 N.Y.S.2d 923, 925 (App. Div. 1985); *Blanton v. Moses H. Cone Mem'l Hosp., Inc.*, 354 S.E.2d 455, 457-58 (N.C. 1987); *Benedict v. St. Luke's Hosps.*, 365 N.W.2d 499, 504 (N.D. 1985); *Park N. Gen. Hosp. v. Hickman*, 703 S.W.2d 262, 266 (Tex. Ct. App. 1985); *Pedroza v. Bryant*, 677 P.2d 166, 170 (Wash. 1984); *Utter v. United Hosp. Ctr., Inc.*, 236 S.E.2d 213, 215 (W. Va. 1977); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 164 (Wis. 1981)).

204 The loss of clinical privileges would have a crippling effect on those physicians whose practice depended on the use of hospital facilities.

205 It has been argued that the existence of the NPDB discourages physicians from settling disputes since one of the consequences of settlement is the reporting of a physician's name to the data bank. *See* Weiler, *supra* note 14, at 1168-69. A sensible

more, the fact that state medical boards are "easing . . . patient access to identifiable data about individual physicians' legal and disciplinary histories [only] heighten[s] physician incentives to avoid adverse legal entanglements . . . ." <sup>206</sup>

It is important to note that quite apart from such external forces, physicians as a group purport to impose a far more demanding standard on themselves and their colleagues than legal strictures—namely through a physicians' standard of "perfection."<sup>207</sup> Physicians in general are conditioned to a "culture of infallibility."<sup>208</sup> According to Professor Marshall Kapp, errors in patient care are seen by physicians as not so much the result of external factors such as poor training, technique, or fatigue, but "as manifestations of unacceptable character flaws . . . ." <sup>209</sup> Professor Kapp also observes that for physicians "being accused in a public forum, such as a court, of committing an error by an external scrutinizer cannot be interpreted . . . in any manner other than as a deeply personal affront."<sup>210</sup>

Consequently, the existence of corporate liability, the NPDB, the facility with which patients are obtaining access to individual physicians' legal and disciplinary history, and the perfectionist mentality that is common among most physicians all arguably serve as checks to deter unacceptable behavior in the delivery of medical care. Contrary to Arkes and Schipani, then, at least some market and other mechanisms comparable to those constraining officers and directors are in place to control the behavior of physicians and assure that patients receive quality medical care. Hence, reliance on market efficiencies

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solution may be to waive mandatory reporting requirements for physicians who settle cases below a certain monetary threshold (Weiler, himself, suggests a \$50,000 threshold as an example to illustrate his point). *Id.* at 1169. Such a compromise seeks to preserve the virtues of deterrence and market mechanisms while also remedying one of the major disincentives that exist to settlement. See Robert Pear, *Group Asking U.S. for New Vigilance in Patient Safety*, N.Y. TIMES, Nov. 30, 1999, at A1. But see *supra* note 194.

206 Kapp, *supra* note 197, at 770; see also Robert Pear, *Inept Physicians Are Rarely Listed as Law Requires*, N.Y. TIMES, May 29, 2001, at A1.

207 Kapp *supra* note 197, at 755 & n.17 (citing LOUIS SNYDER, *Disclosure of Errors and the Threat of Malpractice*, in ETHICAL CHOICES: CASE STUDIES FOR MEDICAL PRACTICE 47, 51 (Louis Snyder ed., 1996)). One study found that in a profession that prizes perfection, error is essentially forbidden. See Marc Newman, *The Emotional Impact of Mistakes on Family Physicians*, 5 ARCHIVES FAM. MED. 71, 72 (1996); see also Daniel H. Novack et al., *Calibrating the Physician: Personal Awareness and Effective Patient Care*, 278 JAMA 502, 505 (1997).

208 Kapp, *supra* note 197, at 755 (quoting Levy, *Code Blue*, 7 HARV. PUB. HEALTH REV. 36, 39 (1995)).

209 *Id.*

210 *Id.* (citing Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994)).

may not sufficiently explain the stark difference between physicians and corporate officers and directors in the eyes of the law.

### G. *Plaintiff's Voluntary Exposure to Risk*

Plaintiff's voluntary exposure to risk is the seventh and final explanation put forth by Arkes and Schipani to explain why physicians and corporate officers and directors are held to a different standard of legal liability. But, like the other six explanations, this does not seem all that persuasive. Arkes and Schipani observe that "unlike many persons in need of medical care, shareholders have voluntarily exposed themselves to risk by investing in a business enterprise."<sup>211</sup> They explain that at any point investors can easily and effortlessly withdraw a particular investment and thereby eliminate their risk.<sup>212</sup> Accordingly, a lower standard of care is seen as the appropriate standard to govern voluntary relationships such as corporation-shareholder.<sup>213</sup> Arkes and Schipani indicate on the other hand, that "persons in need of medical care generally have not voluntarily exposed themselves to a health risk" in the same sense that a purchaser of securities assumes a risk of loss.<sup>214</sup>

Although it is arguably true that there is much less of a voluntary relationship between doctor and patient<sup>215</sup>—especially in an age

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211 Arkes & Schipani, *supra* note 29, at 629.

212 *See id.*

213 Although we add the caveat that this statement should be limited to publicly traded corporations. The ability of shareholders to withdraw their investments is severely restricted in non-publicly traded corporations (such as closely held corporations). Despite the absence of a market in which non-publicly traded shares can be bought and sold, the business judgment rule still applies with equal vigor. For a discussion of the applicability of the business judgment rule in the setting of a closely held corporation and certain circumstances where courts have deviated from the business judgment rule in favor of the "strict fiduciary duty" rule and the "involuntary dissolution" rule, see Davis, *supra* note 76, at 593–94.

214 *See* Arkes & Schipani, *supra* note 29, at 629.

215 Although this would seem to be the better view, it can be argued that patients do voluntarily expose themselves to the treatment of a particular physician just as shareholders voluntarily expose themselves to the decisionmaking of a particular group of officers and directors. Just as shareholders dissatisfied with the former decisions of officers and directors are free to withdraw from a corporation, patients who learn of a physician's unfavorable legal and disciplinary history or second-rate delivery of care (for instance, through word of mouth) are also free to leave such a physician in exchange for what they consider to be a more suitable health care provider. According to this argument, with state medical boards facilitating public access to data banks containing physicians' past legal and disciplinary predicaments, patients, like shareholders, are able to decide whether they are willing to expose themselves to certain risks at the hands of particular physicians or corporate officers and directors.

where HMOs provide less and less freedom of choice for patients—arguably too a voluntary relationship alone does not justify a lower standard of care for either physicians or corporate officers and directors.

Consider the views of Judge Ralph Winter, surely one of the most perceptive analysts of corporate law in or out of the judiciary. True, Judge Winter has emphasized in one of his typically trenchant opinions that investors by diversification can readily lessen their risk of any given holding. They therefore would seem to need less protection by the courts from the (by hindsight) unfortunate risks created for investors by corporate officers and directors compared to the (by hindsight) unfortunate risks created for patients by physicians.<sup>216</sup> But Judge Winter goes on to emphasize two additional factors which justify the business judgment rule that would also seem to justify its (at least partial) extension to physicians. First, the need “that the law not create incentives for overly cautious corporate decisions”<sup>217</sup> that fear of litigation can impart. Much has been made in this Article of the same fear induced by litigation for physicians.<sup>218</sup> Second, Winter enunciates reasoning previously discussed as also very often applicable to physicians:

[C]ourts recognize that after-the-fact litigation is a most imperfect device to evaluate corporate business decisions. The circumstances surrounding a corporate decision are not easily reconstructed in a courtroom years later, since business imperatives often call for quick decisions, inevitably based on less than perfect information. The entrepreneur's function is to encounter risks and to confront uncertainty, and a reasoned decision at the time made may seem a wild hunch viewed years later against a background of perfect knowledge.<sup>219</sup>

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In other words, just as shareholders can research a particular corporation prior to entering into a voluntary relationship with it, this argument contends that patients seeking non-emergency medical attention, particularly one involving high-risk or invasive procedures, likewise can supposedly research the adverse professional history of a physician prior to coming under his/her care. Of course, under an HMO or PPO system, patients may not have as much full freedom to select their health care providers as may be the case in a fee for service regime. But HMOs and PPOs do not completely eliminate patient choice; instead, they allow patients to select health care providers from among a group of physicians contracted with and, often for an additional premium or deductible, even to go outside the approved panel. Therefore, patient choice is restricted, but not eliminated.

216 *Joy v. North*, 692 F.2d 880, 885 (2d Cir. 1982).

217 *Id.* at 886.

218 See *supra* notes 102–09, 117–35 and accompanying text.

219 *Joy*, 692 F.2d at 886.

The key to the business judgment rule, then, and consequently the current difference in legal liability for physicians and corporate officers and directors, by no means turns alone—or even necessarily primarily—on the existence or non-existence of a readily available diversification of risk or any of the other distinguishing factors discussed by Arkes and Schipani. We repeat that what is key is that courts lack the expertise to routinely second-guess the business wisdom of corporate officers and directors, with all the attendant evils of their attempting to do so, especially the risks of error and overdeterrence. And the point is that courts likewise lack the expertise to routinely second-guess the medical decisions of physicians. This truism seems to us to at least equal, and perhaps even dwarfs any talk of diversification, etc., along with any distinction between “deciding versus doing,” a discussion of which follows.

### *H. Deciding Versus Doing*

Although Arkes and Schipani do not rely on the distinction between deciding and doing to explain why physicians and corporate officers and directors are subject to different standards of liability, some writers have attempted to rationalize this difference by such a distinction. As one writer puts it, “[d]irectors do not ‘do’ things in the same sense as doctors, lawyers, architects, or plumbers. Their duties consist principally of overseeing management, establishing corporate policy, and weighing major business transactions.”<sup>220</sup> Others have explained that “what directors do is engage, more or less continuously, in a process of reading, thinking, discussing, inquiring, deliberating and, in the end, deciding.”<sup>221</sup> Although it may be true that officers and directors are engaged over time in such tasks, is that distinction dispositive?

In the first place, like the corporate professional, physicians too exercise discretion, weigh options, make decisions, and then ultimately execute those decisions. In the process of carrying out their duties, physicians likewise must read, think, discuss, inquire, and deliberate. For instance, a surgeon may decide that a patient is in need of an operation. Before recommending surgery, a surgeon can be expected to routinely peruse medical literature, discuss options with colleagues, inquire into the medical history of patients, weigh such various information, and consider alternative forms of treatment. Granted that such “deciding” might be seen as separate from “doing,”

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<sup>220</sup> James J. Hanks, Jr., *Evaluating Recent State Legislation on Director and Officer Liability Limitation and Indemnification*, 43 BUS. LAW. 1207, 1232 (1988).

<sup>221</sup> Balotti & Hanks, *supra* note 73, at 1343.

i.e., executing the decision for example by actually conducting the surgery. To that extent at least, logically, physicians ought be exempt from liability only for "decisions." But focusing so exclusively on the often somewhat tenuous distinction between deciding and doing<sup>222</sup> to carve up exposure to liability for physicians does not seem very promising, even assuming it works for corporate officers and directors. For example, how about "decisions" in the course of unexpected contingencies during surgery?

So which way is the more prudent course as to liability for physicians—no immunity for either deciding or doing, or immunity for both? Neither brings us to our proposed solution, embodying a variant of—and arguably an improvement on—the business judgment rule at least as applied to medical malpractice cases. But before discussing our proposed solution, let us turn briefly to the recommendations of Arkes and Schipani.

### *I. Recommendations by Arkes and Schipani*

Even Arkes and Schipani, despite concluding, "there are legitimate reasons why the standards of care in business and medicine ought to differ," acknowledge that "to the extent the medical malpractice situation subjects physicians to hindsight bias, procedural changes should be made to minimize this judgment error."<sup>223</sup> Arkes and Schipani then recommend three reforms: (1) the development of practice guidelines; (2) the establishment of various arbitration boards; and (3) the use of a bifurcated trial procedure.<sup>224</sup> Of the three reform schemes, they endorse the bifurcated trial procedure as the most promising and practical approach to curtail the effects of hindsight bias.<sup>225</sup> We have already addressed the various shortcomings of practice guidelines,<sup>226</sup> and Arkes and Schipani touch upon some of the

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222 See *supra* note 49.

223 Arkes & Schipani, *supra* note 29, at 630.

224 See *id.*

225 See *id.*

226 See *supra* notes 147–60 and accompanying text. The existence of practice guidelines may actually breed litigation against hospitals. This may occur in four situations. First, hospitals may be held liable for negligently implementing substandard guidelines. John D. Blum, *Hospitals, New Medical Practice Guidelines, CQI and Potential Liability Outcomes*, 36 ST. LOUIS U. L.J. 913, 943 (1992). Second, hospitals may be found liable for a physician's deviation from a guideline if the hospital neglected to utilize the guideline to monitor the physician's course of treatment. *Id.* Third, hospitals that create incentives and penalties that affect a physician's medical judgment and decisionmaking autonomy may be held jointly or solely responsible for a patient's injuries. *Id.* Lastly, a hospital may be held liable if its implementation of practice guidelines leads to the reasonable belief that a physician is an agent of a hospital. See,

drawbacks of arbitration boards, albeit briefly.<sup>227</sup> Their recommendation of bifurcated trials seems similarly subject to challenge as a remedy to existing problems of the tort system.

The use of bifurcated trials is already available in many states.<sup>228</sup> Federal courts also provide for its use under Rule 42(b) of the Federal Rules of Civil Procedure.<sup>229</sup> Bifurcated trials typically allow juries to decide issues of duty of care violations only during the first stage of trial.<sup>230</sup> That is, the determination of liability is only permitted in the first phase. It is only when physicians are held to have departed from applicable standards of care that juries normally decide, during the second stage, issues of damages.<sup>231</sup> Arkes and Schipani reason that "[b]ecause the issue of the physician's care is the only issue decided in the first phase, the jury hears nothing of the patient's pain and suffering or other aspects of the unfortunate outcome. Ignorance of the outcome would tend to minimize the effects of hindsight bias."<sup>232</sup> Though this may be true, the use of bifurcated trials still requires the determination of fault during the first phase of trial and then, if necessary, an assessment of noneconomic losses during the second. Therefore, the use of the bifurcated trial does not remedy the most unfortunate symptoms of modern tort law; instead, it simply separates the tort system's failings into two distinct and separate processes. Merely dividing the tort system's two most crippling faults will not solve the malfunctions affecting the tort system.

This brings us to our proposed solution, embodying a variant of—and arguably an improvement on—the business judgment rule, at least as applied to medical malpractice cases.

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*e.g.*, *Kashishian v. Port*, 481 N.W.2d 277, 286 (Wis. 1992) (dealing with a hospital held liable under apparent authority for the negligence of a physician, who was an independent contractor, because paper with hospital letter head was presented to the patient).

227 See Arkes & Schipani, *supra* note 29, at 632–33.

228 See, *e.g.*, CAL. CIV. CODE § 3295(d) (West 1997); MINN. STAT. ANN. § 549.20(4) (West 1993); MISS. CODE ANN. § 11-1-65(1) (1998); MONT. CODE ANN. § 27-1-221(7) (1991); NEV. REV. STAT. 42.005(3) (1991); N.J. STAT. ANN. § 2A:15-5.13 (West 1997); N.C. GEN. STAT. § 1D-30 (1997); N.D. CENT. CODE § 32-03.2-11(2) (1997); OKLA. STAT. ANN. tit. 23, § 9.1 (West 1998); TEX. CIV. PRAC. & REM. CODE ANN. § 41.008(A) (Vernon 1997); UTAH CODE ANN. § 78-18-1(2) (1996).

229 See Fed. R. Civ. P. 42(b) and amendments (allowing courts to order a separate trial of any claim or any separate issue in furtherance of convenience or to avoid prejudice or when separate trials will lead to expedition and economy).

230 Arkes and Schipani, *supra* note 29, at 633.

231 See *id.*

232 *Id.*



## IV. THE EARLY OFFER PLAN

Abraham Lincoln once said: "Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often the real loser—in fees, expenses, and waste of time."<sup>233</sup> In the same vein, Judge Learned Hand remarked: "I must say that, as a litigant, I should dread a lawsuit beyond almost anything else short of sickness and death."<sup>234</sup> It is with these general concepts in mind that the senior author of this Article has developed an early offers plan. The goal of the early offers plan is to encourage prompt settlement of personal injury tort claims, including those arising from medical malpractice. The early offer approach is not an absolute no-fault rule. Under the early offer regime, the current tort system is retained as an alternative to settlement, and payments are not made automatically upon the happening of a statutorily defined injury, as is the case in workers' compensation and no-fault automobile insurance.<sup>235</sup>

Rather, under the plan, a defendant facing a personal injury claim would have the option of offering the claimant, within a specified period (say, 120 days after a claim), periodic payments of the claimant's net economic loss. Net economic loss under the plan would mandate payment of medical expenses (including rehabilitation) and lost wages not already covered by collateral sources. Also payable would be reasonable attorney fees, which, however, would be much less than the normal 30% or 40% contingency fee given the quick resolution of cases. Crucial is that nothing for pain and suffering, or any other noneconomic loss would be due. Crucial too is that to qualify as a statutory early offer nothing less than the foregoing can be offered. Although acceptance of an early offer by a claimant would end the dispute, in the event that an early offer made by a defendant is rejected by a claimant in favor of litigation, the claimant would then be required to establish a defendant's breach of a lower standard of care (defined as wanton or intentional misconduct) by a higher burden of proof (defined as clear and convincing evidence, or preferably

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233 ABRAHAM LINCOLN, *Fragment: Notes for a Law Lecture (1850)*, in THE COLLECTED WORKS OF ABRAHAM LINCOLN: SUPPLEMENT 1832-1865, at 18, 19 (Roy P. Basler ed., 1974).

234 GERALD GUNTHER, LEARNED HAND: THE MAN AND THE JUDGE 26, 146 (1994) (quoting Learned Hand, *The Deficiencies of Trials to Reach the Heart of the Matter*, Address Before the New York City Bar Association (Nov. 17, 1921), in 3 LECTURES ON LEGAL TOPICS: 1921-1922, at 87, 105 (1926)).

235 See JEFFREY O'CONNELL, THE LAWSUIT LOTTERY: ONLY THE LAWYERS WIN 181-82 (1979).

beyond a reasonable doubt).<sup>236</sup> Should a defendant choose not to make an early offer, an injured victim would have recourse under normal common-law tort principles as to the standard of care, burden of proof, and the extent of damages.

Under this approach, defendants will have a strong incentive to settle many arguably meritorious claims, not merely those with a high likelihood of a claimant's success at trial. Since the absence of an early offer would often result in a claimant pursuing a personal injury action under the existing tort system, defendants should welcome the opportunity to settle claims early in the adjudication process. The early resolution of these cases would allow defendants to avoid the uncertainty of determining at trial both liability and noneconomic damages while simultaneously greatly lessening attorney fees on both sides, which represent the vast bulk of transaction costs.<sup>237</sup> Also, any concerns of higher costs under the early offers regime should be eased by the very fact that a defendant electing to tender an early offer will do so because such a choice—all things considered—is economically prudent.<sup>238</sup> When a defendant is confronted with a manifestly unmeritorious claim, an early offer will not be made since the defendant will rely on the current tort system to dispose of the claim should it be pursued. Simply put, no defendants need to make an offer if they would not do so in the absence of the early offers plan.

But this does not mean that claimants as a class are disadvantaged overall by the early offers scheme. Although claimants who accept early offers waive their rights to recover noneconomic losses such as pain and suffering, loss of consortium, and punitive damages, they correspondingly secure prompt payment of actual losses (to the extent collateral sources are insufficient), plus attorneys' fees, while simultaneously avoiding the uncertainty, delay,<sup>239</sup> and high transaction costs<sup>240</sup> associated with a normal tort claim. Notice that because de-

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236 See O'Connell, *supra* note 24, at 884.

237 Almost three-fifths (57%, as opposed to 47% for motor vehicle claims) of the dollars spent by the health care system on malpractice litigation is expended on attorneys' fees and other transaction costs. Weiler, *supra* note 14, at 1163.

238 In deciding whether to tender an early offer, a defendant will consider the following factors: the amount of net losses versus transaction costs plus monetary high verdict exposure under traditional litigation.

239 Three years is the median period from the occurrence of the medical incident to the malpractice payment. Weiler, *supra* note 14, at 1163.

240 See David S. Starr, *The No-Fault Alternative to Medical Malpractice Litigation: Compensation, Deterrence, and Viability Aspects of a Patient Compensation Scheme*, 20 TEX. TECH L. REV. 803, 806-07 n.23 (1989) (observing that delay tactics, contingent fees, and psychological stress all contribute to significant transaction costs, even for successful litigants); see also Murray L. Schwartz & Daniel J.B. Mitchell, *An Economic Analysis of the*

fendants must still pay claimants' net economic losses, which has the effect of internalizing substantial costs of accidents for defendants, disincentives for defendants to act negligently are addressed. Therefore, unlike the business judgment rule, which more often than not completely immunizes corporate officers and directors from all damages for violations of duty of care, the early offers regime requires a defendant to make a claimant economically whole, thereby avoiding false negatives, before the variant of the business judgment rule attaches in the form of relief from full-blown tort liability through avoidance of noneconomic damages. Only then is such full-blown protection for defendants granted, assuming a claimant accepts the early offer. And a claimant who rejects an early offer still has the opportunity to hold a defendant liable for both economic and noneconomic damages, although admittedly the process of doing so is considerably more onerous. (Note, an early offers bill would allow all other potentially liable parties to join or be joined in the early offer, with any ultimate shares of paying claims decided by arbitration among all the offerors.)

We reach here an issue of real bite: because personal injury claims—unlike all other damage claims—routinely entail damages for both economic and noneconomic loss, it becomes uniquely feasible to allow defendants *ex ante* to not only make, but enforce, a socially attractive settlement; this involves claimant's acceptance of defendant's prompt offer of payment of economic damages in return for waiver of noneconomic damages, with statutory sanctions of a lower standard of care proven with a higher burden of proof if the offer is refused. This means that pursuit of a common-law claim for full damages is allowed only with a higher burden of proof of a lower standard of care. Obviously, in non-personal injury claims, where only economic damages are at stake, no similarly equitable means are available to sanction a claimant who refuses to accept an offer of only a portion of total damages claimed.

As emphasized throughout this Article, the fault criterion of ordinary negligence is an unsound basis to predicate liability, and ultimately serves as one of the two major shortcomings of the existing tort system.<sup>241</sup> Because such fault is ill-suited for purposes of administering liability, verdicts, for example, can be grounded in sympathy for

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*Contingent Fee in Personal-Injury Litigation*, 22 STAN. L. REV. 1125, 1125 (1970) (stating that the greatest single cost for a claimant is the contingent fee).

241 See *supra* notes 10–13 and accompanying text.

the plaintiff, not the substandard conduct of the defendant.<sup>242</sup> Under protection similar to the business judgment rule<sup>243</sup>—which we emphasize is basically what the early offers regime achieves—triers of fact would not be called on to toil through mountains of technical, confusing, and often contradictory evidence in order that liability for ordinary negligence be imposed. Like the business judgment rule, the early offers approach is predicated on the belief that courts are normally ill-suited to second-guess the expertise and acumen of highly skilled professionals. As second-guessing in the business context hampers, not advances, the delivery of goods and services by corporate America, so too second-guessing in the medical context often hinders, not furthers, the delivery of quality medical care.<sup>244</sup> Essentially, the early offers approach provides that absent the equivalent of bad faith in the decisionmaking process or in the execution of the decision, a court will not substitute its judgment for that of the defendant once an early offer has been tendered. Wanton misconduct thus can be seen as the equivalent of bad faith under the business judgment rule, with both being relatively rare and difficult to prove.<sup>245</sup>

The existence of a lower standard of care once an early offer has been rejected would allow triers of fact *ex post* to recognize the ready distinction between conduct within the arguable ambits of due care and wantonness should a claim withstand a pretrial motion to dismiss and reach trial stage. To illustrate, as the following table shows, on a scale of one to ten, it is difficult to tell the difference between, say, 4 and 5 or between 8 and 9, but not so for the difference between 4 and 9.

Due care	Negligence	Wanton
1-4	5-8	9-10

Similarly, this mathematical progression allows potential defendants *ex ante* a better signal for what misconduct full-scale liability will be assessed. Potential defendants would seek to avoid conduct approaching the mid-range of numbers for fear that conduct that might be measured at, say, 7 or 8, could be construed as 9. Thus, the availa-

242 See Jeffrey O'Connell, A "Neo No-Fault" Contract in Lieu of Tort: *Preaccident Guarantees of Postaccident Settlement Offers*, 73 CAL. L. REV. 898, 900 (1985); see also Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1966 (1996) (indicating that a plaintiff's degree of disability, not a defendant's negligence, is most statistically correlated with tort recovery).

243 Under the business judgment rule, quality of care is typically measured by concepts of bad faith or a lower standard of care.

244 See *supra* notes 102-09, 117-23 and accompanying text.

245 See *supra* notes 57-62, 66-68 and accompanying text.

bility of damages for pain and suffering (not to speak of punitive damages) should have the effect of deterring potential defendants from even flirting with negligent conduct that could potentially be labeled as wanton.<sup>246</sup>

The ability to thus discriminate between extremes will make the imposition of full-scale liability for physicians less vagarious and random, greatly lessening the often counterproductive (even pernicious) effects of fortuitous litigation that now loom over medical care. Even if determinations of wanton misconduct and noneconomic damages would still on occasion have to be assessed,<sup>247</sup> the need to perform such inquires would be greatly reduced since relatively few defendants can be expected to breach the lower due care standard of the early offers regime.<sup>248</sup> The efficacy of the lower standard of care (i.e., wanton misconduct) is reinforced by the need to prove it by a higher burden of proof (i.e., beyond a reasonable doubt). These "twin peaks," it will be noted, mirror criminal standards designed to avoid false positives. But that protection for a claimant is buttressed by the requirement that a defendant only avoid false positives by also avoiding false negatives (unlike under criminal law or the business judgment rule) by offering promptly to pay a claimant's net economic losses. In that connection, to further avoid fears that payment of only net economic losses may be derisory for those already relatively completely covered for their economic losses by collateral sources, e.g., pensioners or homemakers with adequate health care coverage and no wage loss, the early offers bill could provide that seriously injured claimants, as rigorously defined under the statute, must be offered a choice between payment of net economic losses or a lump sum of, say, \$500,000.

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246 See O'Connell, *supra* note 24, at 879-80.

247 Damages awarded after the imposition of liability has been determined (for a breach of a lower standard of care) would be expected to be great—even higher than damages that are currently awarded for tortious duty of care violations. The ability of claimants to overcome the hurdles imposed by the early offers regime would likely be viewed as a sign of greater culpability on the part of defendants. Triers of fact may then deem it appropriate, and rightfully so, to award punitive damages for the plaintiff. The possibility of such exorbitant damages, albeit slim, serves as a powerful deterrent against suboptimal physician conduct. As it already stands, the average medical malpractice award, adjusted for the severity of a victim's injury, is twice as high as product liability cases and three times as high as motor vehicle cases. See Weiler, *supra* note 14, at 1174 (citing Randall R. Bovbjerg et al., *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, LAW & CONTEMP. PROBS., Winter 1991, at 5, 16-21).

248 For a more detailed explanation concerning the functioning of pain and suffering at the punitive level, see O'Connell, *supra* note 24, at 886-89.

Note, too, that the combination of proof of a lower standard of care by a higher standard of proof will also mean that through such stringent criteria, judges will be in a very strong position to control any jury aberrations by summary judgments, directed verdicts, or judgments n.o.v. Note further too that these exacting standards will also make it harder for claimants to retain responsible (and therefore more credible) expert witnesses willing to characterize a defendant's misconduct as so irresponsible as to justify being labeled egregious. And even if induced to do so, it will be harder for any expert so testifying to withstand cross-examination.

Although this Article has focused on medical malpractice claims against physicians, its theory that the thrust of the business judgment rule be adapted to health care claims need not be thus limited. Indeed, given increasing recognition that medical misadventures stem from complex, interactive, systemic factors involving the entire health care community—by no means limited to physicians—the early offers regime should arguably be extended to the entire universe of health care providers. Otherwise, plaintiffs' attorneys, foreclosed from full-blown claims against physicians, will be straining to claim against health care providers other than physicians. Indeed, funds from early offers by physicians would be used to finance litigation against such non-physician providers. Thus, a statutory proposal to apply early offers to federally funded health care (such as Medicaid and Medicare) defined health care providers to include hospitals (psychiatric and otherwise), skilled nursing facilities, home health agencies, rural health clinics, comprehensive outpatient rehabilitation facilities, hospice programs, doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.<sup>249</sup>

Furthermore, as stated above, product liability claims mirror medical malpractice cases in their complexity and consequent demands for expert witnesses.<sup>250</sup> Thus, the early offers approach similarly could be applied to product liability, thereby also avoiding courts routinely being forced to play the role of "appellate engineers."<sup>251</sup> Indeed, a more recent federal bill sponsored by Senator Mitch McConnell (R., Ky) authorizes early offers to almost all personal injury cases most of which, after all, are "unbounded."<sup>252</sup> (Auto accident claims

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249 See 131 CONG. REC. 17,775 (1985) (utilizing the definitions of 42 U.S.C. § 1395 (1984)).

250 See *supra* notes 163–67 and accompanying text.

251 See *Dawson v. Chrysler Corp.*, 630 F.2d 950, 953 (3d Cir. 1980).

252 S. 1861, 104th Cong. (1996).

against motorists are excluded from the bill on the grounds that they are better dealt with by genuinely effective no-fault auto legislation.)<sup>253</sup> On the other hand, the earlier federal early offers bill sponsored by Rep. Richard Gephardt (D., Mo.) limited itself, as indicated above, to medical malpractice claims arising only from federally funded health care, and a bill sponsored in Massachusetts by then Governor Michael Dukakis limited itself to claims arising from general surgery.<sup>254</sup> A further use could apply the early offers approach to the currently raging political dispute over the right of patients to sue their HMO (often prevented under applicable federal law). Under such a compromise, any right to sue the HMO would be subject to the right of the HMO to make the binding early offer described above. Better than simply expanding the notoriously adverse effects of allowing more malpractice claims or, at the other end of the spectrum, simply preventing malpractice claims against HMOs as under present law, applying the early offers regime to HMOs can be seen as a responsible compromise.<sup>255</sup> Thus, an early offers bill can be either narrow or broad in its scope.

### CONCLUSION

Though many explanations have been put forth to help unravel why a different standard of liability exists for physicians and corporate officers and directors, ultimately these justifications either prove too much or too little. Much of the reasoning that supports the existence of the business judgment rule likewise applies to health care and other enterprises. The real difference can be found in the effect that the dissimilar rules have had on two activities. Overall, physicians have functioned under a cloud of fear and have understandably taken measures to reduce their exposure to liability—oftentimes by unnecessarily increasing costs for the entire health care system. Conversely, corporate officers and directors have had the relative peace of mind that accompanies professional independence and judicial deference to decisionmaking. And, given the astonishing commercial success of the American corporation throughout the years—and especially recently, at least pre-September 11, 2001—can it be convincingly maintained that the American economy has suffered from thus freeing

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253 H.R. 3084, 99th Cong. (1985).

254 Mass. House Bill no. 5700 (May 1986).

255 For a proposal that early offers be used for claims against HMOs as a compromise to their full scale liability versus complete immunity, see Jeffrey O'Connell & James F. Neale, *HMO's, Cost Containment and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL'Y 287, 310-13 (1998).

corporations under the business judgment rule from the lash of litigation?

The early offers approach seeks to provide some much-needed protection from the frustrations of litigation for physicians and other professionals as well as for injured parties. Through the use of a lower standard of care and a higher burden of proof once an early offer has been tendered, it would be expected that the early offers regime would achieve results similar to the business judgment rule. But, unlike the business judgment rule, the added protection afforded to defendants by the early offers plan is not triggered until a defendant has agreed to provide economic redress. Therefore, the early offers plan does not simply immunize a defendant from liability; rather, it makes the imposition of fuller liability much more difficult only after lesser liability for essential economic losses has been assumed.

The time is ripe for changes in the resolution of medical malpractice litigation. The early offers plan imparts hope for much improvement in the adjudication of these cases (and others)<sup>256</sup> bottomed as it is in the time-tested wisdom of the business judgment rule.

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256 See *supra* notes 251–52 and accompanying text.



## APPENDIX

## TOOLS OF THE EARLY OFFERS PLAN

A. *Lower Standard of Care*

Articulated in legal terminology, the word "wanton" is characterized by extreme recklessness or foolhardiness.<sup>257</sup> In its ordinary accepted sense, it connotes "perverseness exhibited by deliberate and uncalled for conduct, recklessness, disregardful of rights and an unjustifiable course of action."<sup>258</sup> Wanton conduct is defined as an:

[a]ct or failure to act, when there is a duty to act, in reckless disregard of rights of another, coupled with a consciousness that injury is a probable consequence of act or omission. Term refers to intentional act of unreasonable character performed in disregard of risk known to him or so obvious that he must be taken to have been aware of it and so great as to make it highly probable that harm would follow and it is usually accomplished by conscious indifference to the consequences.<sup>259</sup>

Compare the definition of negligence:

The failure to use such care as a reasonably prudent and careful person would use under similar circumstances; it is the doing of some act which a person of ordinary prudence would not have done under similar circumstances or failure to do what a person of ordinary prudence would have done under similar circumstances . . . . [Also], the term refers only to that legal delinquency which results whenever a man fails to exhibit the care which he ought to exhibit, whether it be slight, ordinary, or great. *It is characterized chiefly by inadvertence, thoughtlessness, inattention, and the like, while "wantonness" or "recklessness" is characterized by willfulness.*<sup>260</sup>

To a legally trained mind, the definitions of wanton conduct and negligence embody highly different criteria of liability. Obviously, simple negligence is inherently easier to establish because it measures the defendant's careless conduct against the objective standard of the reasonably prudent person. On the other hand, wanton conduct entails more than just carelessness, but heinous conduct—a relatively subjective criterion.

Though perhaps jurors will be unable to precisely articulate the difference between wantonness and negligence, essentially, for many jurors, the difference boils down to a distinction between perversity

257 BLACK'S LAW DICTIONARY 1582 (6th ed. 1990).

258 Botto v. Fischesser, 189 N.E.2d 127, 130 (Ohio 1963).

259 BLACK'S LAW DICTIONARY, *supra* note 257, at 1582.

260 *Id.* at 1032 (emphasis added).

and carelessness. Jurors can readily draw on past personal experiences to accentuate the bright-line that exists between these two standards of care. For jurors, the question will simply be, "Was the defendant's conduct perverse or was it just careless?"—with a manifest difference between the two. Therefore, holding physicians to a lower standard of care under the early offers regime when offers are rejected should help eliminate the arbitrary and erratic nature under which determinations of liability are made and consequently make the imposition of liability more consistent and fair. This is especially so if the wanton conduct must be proven by a higher burden of proof such as beyond a reasonable doubt.<sup>261</sup> And it is to the latter standard we now turn.

### B. *Higher Burden of Proof*

The second tool of the early offers plan is the requirement that a claimant prove beyond a reasonable doubt that a tortfeasor engaged in wanton or intentional misconduct.<sup>262</sup> The question thus remains whether jurors will be able to discriminate between the preponderance of the evidence standard of proof under the current tort system and the beyond a reasonable doubt standard of proof recommended by the early offers approach, just as they should be able to distinguish between negligence and wanton misconduct. Will jurors be able to draw the distinction between these two standards of proof, thereby making the early offers approach an effective vehicle for the substantial reduction of false positives (while also greatly reducing false negatives through a corollary payment of net economic losses)?

The heightened standard of proof utilized by the early offers approach is, of course, modeled after that of the criminal justice system (as is the highly anti-social element in wanton misconduct).<sup>263</sup> The

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261 See *infra* text accompanying notes 292–99.

262 This Article focuses mainly on the "beyond a reasonable doubt" standard of proof as opposed to one calling for "clear and convincing evidence." Because "beyond a reasonable doubt" embodies the highest standard of proof available in the American legal system, it seems more appropriate to allow the triers of fact to distinguish between the lowest standard of proof, by a preponderance of the evidence, and by the highest standard of proof, beyond a reasonable doubt. But see *infra* notes 293–300 and accompanying text.

263 The first thing to note is that civil and criminal actions involve highly different stakes. After execution, incarceration represents the ultimate consequence of conviction under the criminal justice system. The substantive and procedural safeguards instituted by the criminal adjudication process are in effect designed to prevent a great outrage—an innocent person being temporarily or permanently deprived of freedom through a false positive. In contrast, the consequences of tort liability are wholly monetary or equitable in nature. Therefore, some critics may object to civil

criminal system demands each juror to presume the innocence of an accused until guilt is established by the beyond a reasonable doubt test. The presumption of innocence, although not articulated in the Constitution, is a basic element of a fair trial under our criminal justice system.<sup>264</sup> The presumption of innocence places the burden of proof on the state, while the reasonable doubt standard represents the level of proof required to satisfy the burden.<sup>265</sup> This tandem of standards of presumption of innocence and proof beyond a reasonable doubt results in a criminal trial not only asking whether a defendant is guilty, but rather, whether a defendant is *certainly* guilty.<sup>266</sup> Though at first glance this may seem easy enough, the beyond a reasonable doubt standard can be ticklish: The reasonable doubt standard requires jurors to apply an "appropriate level of skepticism."<sup>267</sup> Skepticism is uncertainty—"the refusal to believe insufficiently proven facts or conclusions."<sup>268</sup> Basically, skepticism is doubt. But if defining reasonable doubt is elementary, defining what makes a particular doubt reasonable is much more troublesome.<sup>269</sup> This is especially true because the brink of reasonable doubt is by definition the brink of unreasonable doubt.<sup>270</sup> More precisely, reasonable doubt is defined as that, "doubt based on reason and arising from evidence or lack of evidence, and it is doubt which a reasonable man or woman might

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and criminal standards of proof being equalized. Such critics may argue that the relative importance that society places on the consequences of civil and criminal verdicts reflect how certain a jury must be before it can sanction a civil or criminal defendant under the respective systems. On the other hand, tools available in one system should arguably be used to remedy serious problems existing in the other. Unless conclusive empirical evidence suggests that there are serious adverse consequences involved in uniformity of proof for both criminal and civil proceedings (such as the "beyond a reasonable doubt" standard becoming weakened, thereby resulting in the use of less skepticism by jurors), there is little reason why a standard of proof that has worked well in one system should not be utilized in the other, especially with the safeguards of the early offers proposal. See O'Connell, *supra* note 24, at 871. But see *infra* notes 293-300 and accompanying text.

264 See *Estelle v. Williams*, 425 U.S. 501, 503 (1976).

265 Scott E. Sundby, *The Reasonable Doubt Rule and the Meaning of Innocence*, 40 *HASTINGS L.J.* 457, 458 (1989).

266 Henry L. Chambers, Jr., *Reasonable Certainty and Reasonable Doubt*, 81 *MARQ. L. REV.* 655, 658 (1998).

267 *Id.* at 656.

268 *Id.* at 666.

269 See *Victor v. Nebraska*, 511 U.S. 1, 18 (1994) (upholding a jury instruction defining reasonable doubt as "such a doubt as would cause a reasonable and prudent person, in one of the graver and more important transactions of life, to pause and hesitate before taking the represented facts as true and relying and acting thereon").

270 See Chambers, *supra* note 266, at 670.

entertain, and it is not fanciful doubt, is not imagined doubt, and is not doubt that juror might conjure up to avoid performing unpleasant task or duty."<sup>271</sup> Reasonable doubt does not require a juror to be absolutely or mathematically certain of a defendant's guilt.<sup>272</sup> Such levels of proof are only attainable through strict logical proof that are impossible to mimic in an adjudication process because of the fallible nature of trial evidence.<sup>273</sup> Any fact-finding system that operates under a requirement of absolute certainty would call for jurors to "believe that absolutely no possibility of innocence existed."<sup>274</sup> Needless to say, a system imposing such a huge burden would be highly inefficient and would make convictions nearly impossible.

Practical or moral certainty,<sup>275</sup> however, represents the maximal level of certainty that a juror can have when absolute certainty is lacking.<sup>276</sup> It has been equated with proof beyond a reasonable doubt.<sup>277</sup> Reasonable doubt "is not mere possible doubt; because everything relating to human affairs, and depending on moral evidence, is open to some possible or imaginary doubt."<sup>278</sup> Jurors who exonerate a defendant just because they believe that there may exist unrepresented evidence that might plausibly explain the defendant's actions would have mistakenly substituted *unreasonable* doubt for the reasonable doubt standard.<sup>279</sup> Although the difference between reasonable doubt and unreasonable doubt can be thus asserted, admittedly whether a particular doubt is reasonable or unreasonable may be very difficult to resolve with certainty in the course of a jury's fact-finding inquiry.

A simple test can direct jurors to acquit a defendant if they are able to construct a reasonable scenario, using all the evidence

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271 BLACK'S LAW DICTIONARY, *supra* note 257, at 1265.

272 See Chambers, *supra* note 266, at 660.

273 See *id.*

274 *Id.*

275 For the purposes of this Article, the slight difference that some find between practical and moral certainty is inconsequential. For explanations of both practical certainty and moral certainty see *id.* at 662 n.29 (citing BARBARA J. SHAPIRO, BEYOND REASONABLE DOUBT AND PROBABLE CAUSE 1-41 (1991); Peter Tillers, *Intellectual History, Probability and the Law of Evidence*, 91 MICH. L. REV. 1465 (1993) (reviewing Shapiro's book *Beyond Reasonable Doubt and Probable Cause*); Steven L. Smith, *Skepticism, Tolerance, and Truth in the Theory of Free Expression*, 60 S. CAL. L. REV. 651 (1987)).

276 *Id.* at 662-63.

277 *Id.* at 663. For an extensive theoretical discussion and breakdown of reasonable doubt, with an examination of subjective and objective reasonable doubt see *id.* at 687-97.

278 *Id.* at 669 n.61 (quoting Anthony A. Morano, *A Reexamination of the Development of the Reasonable Doubt Rule*, 55 B.U. L. REV. 507, 511 (1975)).

279 *Id.* at 670.

presented, suggesting the innocence of a defendant.<sup>280</sup> Such a test would be in accord with the practical certainty standard of reasonable doubt, for it assures that a juror is as certain as feasible of the defendant's guilt before voting to convict. Further, such a test focuses on the process rather than on the verdict.<sup>281</sup> It provides a mere description as to how to remove reasonable doubt rather than stating an iron-clad test as to what could or could not be reasonable doubt. Essentially, this test forces jurors to entertain whether it is reasonably plausible that the accused did not commit the wrong. The focus therefore shifts from the reasonable possibility of guilt to the reasonable possibility of innocence. In short, doubt becomes reasonable doubt when a juror can "construct a reasonable scenario, consistent with the evidence, under which a defendant is innocent . . . because that reasonable scenario may reflect truth."<sup>282</sup>

Conceptually, there are three positions that a juror can have concerning the guilt of an accused. A juror can be certain of a defendant's innocence, uncertain of a defendant's guilt or innocence, or certain of a defendant's guilt.<sup>283</sup> Certainty and belief are not synonymous. Oftentimes, the line drawn by jurors between guilt and innocence (certainty), and between belief and disbelief are not superimposed upon one another.<sup>284</sup> For instance, for our present purposes, a juror may believe that a defendant was wanton, yet be uncertain as to whether this is so. Although evidence may support such a belief, and the belief may ultimately be true, mere belief does not constitute evidence satisfactory to arrive at practical certainty.<sup>285</sup> Since reasonable doubt is based on uncertainty, a correct application of the reasonable doubt standard would require that the accused be absolved.

On the other hand, the preponderance of the evidence or "more likely than not" standard of proof means that the evidence presented is of "greater weight or [is] more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not."<sup>286</sup> The term preponderance in this context does not mean a greater quantity

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280 *Id.* at 682.

281 *Id.*

282 *Id.* at 684.

283 *See id.* at 663.

284 *See id.*

285 *See id.* at 664.

286 BLACK'S LAW DICTIONARY, *supra* note 257, at 1182 (citing *Braud v. Kinchen*, 310 So. 2d 657, 659 (La. Ct. App. 1975)).

of evidence; instead, it refers to the probative force of the evidence.<sup>287</sup> Unlike the reasonable doubt standard, the preponderance of evidence standard of proof does not require the erasure of all reasonably lingering doubts in the minds of jurors before liability becomes proper within the confines of the tort system. Rather, it requires jurors not to find liability unless the weight of the evidence supporting liability—taken as a whole—outweighs the other side favoring nonliability. Figuratively, the standard requires attorneys on both sides to place evidence on a scale of justice<sup>288</sup> that initially tilts in favor of the defendant.<sup>289</sup> At the conclusion of trial, after all proper evidence has been placed on the arms of justice, the scale typically will tip in favor of one outcome over another. Normally, both arms of justice will bear weight suggesting that a tortfeasor could or could not be held liable.<sup>290</sup> However, in the eyes of the law, the preponderance of evidence standard of proof demands that the side with the superior evidence be held victorious. Essentially, this standard of proof requires a claimant to present enough evidence to cause the arms of justice to move from the side supporting the tortfeasor beyond the point of equipoise<sup>291</sup> to the side favoring the claimant.

The difference lies in the fact that the preponderance of evidence standard is a lesser-included standard within the beyond a reasonable doubt standard of proof. Once jurors have been satisfied by

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287 See FLEMING JAMES, JR. ET AL., CIVIL PROCEDURE § 7.14, at 339–40 (4th ed. 1992).

288 This scale tips according to the superiority, not the quantity, of evidence.

289 The scale initially favors the defendant because normally it is the plaintiff who bears the burden of proof. That is, the plaintiff must supply evidence to satisfy the burdens of production and persuasion. In many regards the plaintiff's burden of proof can be viewed as a "presumption of innocence" of the defendant. Therefore, the defendant need not present any evidence since failure on the part of plaintiffs to satisfy their burden should result in nonliability. *But see* Haft v. Lone Palm Hotel, 478 P.2d 465, 473–77 (Cal. 1970) (utilizing a burden-shifting device requiring the defendant to prove that even if a sign was placed at the pool, more probably than not the plaintiffs would have drowned anyway).

290 This is because normally the case would not have gone to trial if both sides did not have admissible evidence to persuade the triers to find in their favor. Even if a tortfeasor does not introduce evidence at trial supporting his/her exoneration, recall that the arms of justice initially were tilted in favor of the defendant because of the burden of proof the plaintiff carries.

291 Equipoise is not sufficient because if all evidence has been presented and the arms of justice rest in balance, then the claimant has not satisfied his/her burden of proof. The claimant has not shown that more probably than not (51% or greater) the accused tortfeasor committed the acts (or should have acted if he had a duty) and must therefore be held liable. When the scale of justice is in equilibrium that suggests that the tortfeasor conceivably could be, but does not support a finding that the tortfeasor is more probably than not, liable.

the latter standard, by definition, they have been satisfied by the former. The reverse is not true. Just because jurors satisfy themselves by the preponderance of evidence standard of proof does not mean that they have satisfied themselves by the beyond a reasonable doubt standard. The preponderance of evidence standard permits jurors to have reasonable doubts concerning the accountability of a defendant while still holding a defendant liable. The preponderance of the evidence standard of proof asks is the defendant *probably*<sup>292</sup> guilty, not is the defendant very clearly guilty.

Under preponderance of evidence, then, much less is required of plaintiffs (and conversely, much more of the defense) in the quality of lawyering, the quality of expert testimony, and the overall quality of evidence. Certainly, the possibility of there being a false positive increases since the mere existence of evidence which creates doubt as to the guilt of defendants is not sufficient to allow them to avoid liability. But note again, if, as a corollary of early offers, the possibility of false positives is much less under a standard of beyond a reasonable doubt, the possibility of false negatives has itself been negated by the prerequisite that a defendant must offer to make the claimant economically whole before invoking a rule that lessens the likelihood of a false positive.

How clear in practice is the difference between the preponderance of evidence standard and beyond a reasonable doubt? In a study by sociologist Rita Simon, an authority on the jury, a sample of judges and actual jurors were asked to quantify on a scale of 1 to 10 their understanding of (1) beyond a reasonable doubt and (2) preponderance of the evidence.<sup>293</sup> Judges quantified "beyond a reasonable doubt" as equaling an 8.9 probability on the 1 to 10 scale; jurors quantified it at 8.6, indicating that judges and jurors see the criminal burden of proof very similarly.<sup>294</sup> But as to "by a preponderance of the evidence" judges quantified this at 5.5 probability, whereas jurors quantified it at 7.5.<sup>295</sup> In the words of the study, "Thus for . . . lay groups, the difference between criminal . . . and civil . . . standards are much less than they are for the judges. The judges make a much sharper distinction between the criminal and civil standards."<sup>296</sup> For the judges, a preponderance means a little more than half, for the

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292 "Probably" means 51% or greater.

293 Rita James Simon & Linda Mahan, *Quantifying Burdens of Proof: A View from the Bench, the Jury, and the Classroom*, 5 LAW & SOC'Y REV. 319, 324-25 (1971).

294 *Id.* at 325.

295 *Id.*

296 *Id.*; see also Jeffrey O'Connell, *Jury Trials in Civil Cases*, 58 ILL. B.J. 796, 807-08 (1970).

jurors it means a probability almost indistinguishable from the standard of criminal trials. The Simon study also purported to show that how one quantifies a burden of proof *does* influence one's verdict.<sup>297</sup>

The Simon study at least draws into question, then, how much difference the heightened burden of proof may make in jury trials. On the other hand, not only is the study dated, but, because it was based on such a relatively small sample of jurors, the study itself cautioned that "further work needs to be done" on the possible discrepancy between judge and jury understanding on burdens of proof.<sup>298</sup> In this connection, the much more ambitious Chicago jury study—on which Professor Simon worked and which is also dated—found striking consonance between judge and jury verdicts as to liability in civil cases.<sup>299</sup> A much more recent jury study by Duke Law Professor Neil Vidmar also purports to confirm the reliability of jury verdicts in medical malpractice cases.<sup>300</sup>

In sum, we hypothesize that for our present purposes, because what is being tested by the heightened burden of proof when an offer to pay a claimant's out-of-pocket losses is rejected is the perverse conduct of wanton behavior, few jury false positives with their hindsight bias need be feared. Indeed, the criterion of beyond a reasonable doubt is, in our view, sufficiently strong that one can hypothesize that it could be effectively combined under an early offers regime with the lesser standard of conduct of gross negligence as opposed to wanton misconduct. Gross negligence is defined as "[t]hat entire want of care which would raise [the] belief that [the] act or omission complained

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297 See O'Connell, *supra* note 296, at 808.

298 *Id.*

299 See Harry Kalven, Jr., *Juries in Personal Injury Cases: Their Functions and Methods*, in *TRAUMA AND THE AUTOMOBILE* 335, 343 (William Curran & Neil Chayet eds., 1966). It should be pointed out, though, that the findings of Kalven and Zeisel on the agreement between judge and jury are undermined as based on questionable statistical data as Kalven and Zeisel cautiously concede. See HARRY KALVEN & HANS ZEISEL, *THE AMERICAN JURY* 33–34 (1966); see also Michael H. Walsh, *The American Jury: A Reassessment*, 79 *YALE L.J.* 142 (1969) (reviewing the Chicago Jury Project, documented by Kalven & Zeisel in *The American Jury*).

300 See NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* 265–77 (1995). But see Theodore Eisenberg, *Judicial Decisionmaking in Federal Products Liability Cases, 1978–1997*, 49 *DEPAUL L. REV.* 323, 333 (1999) (assessing judicial performance in products liability cases and concluding that awards in judge-tried cases exceed those in jury-tried cases); O'Connell & Pohl, *supra* note 7, at 368–79. For another comparison of tort cases generally, see BUREAU OF JUSTICE STATISTICS BULLETIN, U.S. DEPT. OF JUSTICE, *CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES 1976* (NCT-173426 1999), reported in Edward Walsh, *Plaintiffs' Edge: Trial by Judge, but Juries More Generous with Damage Awards*, *WASH. POST*, Sept. 2, 1999, at A10.



of was [the] result of conscious indifference to [the] rights and welfare of persons affected by it."<sup>301</sup>

Admittedly, the cases are replete with confusion as to the difference between various lower standards of care beyond simple negligence, i.e., gross negligence, recklessness, wantonness, and willfulness.<sup>302</sup> If, however, buttressed by a higher burden of proof, any such criterion probably can be effective. Indeed, we go so far as to suggest that if politically desired, a gross negligence standard of conduct could even be combined in an early offers regime with a clear and convincing evidence standard of burden of proof. Even if, for whatever reason, these less clear-cut standards provide insufficient immunity to full-scale liability for common-law damages, keep in mind there is the ultimate safeguard that early offers need simply not be made.

A final note: A further ready means of defining the backup criteria for both standard of care and burden of proof when early offers are rejected—and one which incorporates any jurisdiction's own long accepted terminology as to both—would simply provide that when an early offer is rejected, no claimant can recover unless he or she establishes a case justifying punitive damages under current state law. If the criterion for punitive damages is deemed too porous, as many contend,<sup>303</sup> some jurisdictions have moved to tighten the requirements therefor by, for example, requiring a conscious disregard for the safety of others<sup>304</sup> provable beyond a reasonable doubt<sup>305</sup> or by clear and convincing evidence.<sup>306</sup> And even without such provisions, punitive damages, contrary to mythology, are said to be relatively rare in cases of personal injury compared to commercial disputes.<sup>307</sup>

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301 BLACK'S LAW DICTIONARY, *supra* note 257, at 1033–34 (citing *Claunch v. Bennett*, 395 S.W.2d 719, 724 (Tex. Civ. App. 1965)).

302 *E.g.*, *Hering v. Hilton*, 147 N.E.2d 311, 313–14 (Ill. 1958); *Srajer v. Schwartzman*, 188 P.2d 971, 975–76 (Kan. 1948); *Elliott v. Peters*, 185 P.2d 139, 142–43 (Kan. 1947); *Helleren v. Dixon*, 86 N.E.2d 777, 780 (Ohio 1949).

303 *See, e.g.*, *O'Connell*, *supra* note 24, at 889 n.82.

304 *See, e.g.*, COLO. REV. STAT. ANN. § 13-121-102(1)(b) (West 1999).

305 *See, e.g.*, *id.* § 13-25-127(2).

306 *See* MINN. STAT. § 549.20.1(a) (Supp. 1999); *see also* *Rodriguez v. Suzuki Motor Corp.*, 936 S.W.2d 104, 111 (Mo. 1996) (overruling a case that rejected a higher standard of proof).

307 *See* E. MOLLER ET AL., PUNITIVE DAMAGES IN FINANCIAL INJURY JURY VERDICTS, at xiii (1997) (noting that financial injury disputes account for almost half of the punitive awards, which are awarded in less than four percent of all verdicts).